A MARGINAL ELITE?

A STUDY OF AFRICAN REGISTERED NURSES IN THE GREATER DURBAN AREA.

by

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ACKNOWLEDGEMENTS

This thesis is the result of twelve months' research among some of the one-thousand-odd African registered nurses who, during 1970, were working in the Durban area. In the course of this research, many people assisted me, both as individuals, and as incumbents of official positions. Although it is impossible to acknowledge by name everyone who assisted my investigations, I should like to place on record my gratitude to them. In particular, I wish to thank Dr. C. D. Orchard, medical superintendent of the McCord Zulu Hospital; Dr. M. Nupen, medical superintendent of Clairwood Hospital; and Dr. Anthony Barker, medical superintendent of the Charles Johnson Memorial Hospital, all of whom went out of their respective ways to assist me at all times, with problems of no direct concern to themselves. Likewise, Sr. Columba Hoch, chief matron of St. Mary's Hospital, and the matrons and nursing staff of many other hospitals, must be thanked for their patience and co-operation.

To my supervisors I am also indebted. Professor Eileen Jensen Krige, under whom I did my initial training in Social Anthropology, was responsible for the suggestion that a study of African nurses should be undertaken, and she directed the research in its opening stages. I am extremely grateful for her advice and continuing interest and encouragement. Dr. Eleanor Preston-Whyte shouldered the task of guiding the latter part of the fieldwork, and offered much helpful advice during the most difficult fieldwork period. Finally, Professor W. J. Argyle, who assumed the Chair of Social Anthropology at the beginning of 1971, has supervised the writing of this thesis. His comments, suggestions and advice have been invaluable to me. To have had three supervisors in the course of two years is, perhaps, unusual, and was the result of unusual movement within the Department of African Studies: I should like to thank all three for ensuring continuity in the supervision of my work.

My sincere thanks are due to all those nurses who so freely and willingly gave up their spare time in order to make this study possible, and who accepted me as a friend, as well as an anthropologist. In particular, I owe innumerable insights to the philosophical mind of Mrs. Lillian Gumede, who, although I worked alone, could well have been regarded as my research assistant. I hope, should any of my informants read this dissertation, they will not consider their time to have been wasted.

Finally, I must acknowledge the financial assistance of the Human Sciences Research Council (of South Africa), in the form of a bursary to read for a Master's degree. The opinions expressed and conclusions reached in this thesis, however, are mine alone, and must not be regarded as a reflection of the opinions and conclusions of the Human Sciences Research Council. Similarly, I must assume full responsibility for any errors in fact or in interpretation, which may be present in this dissertation.

INTRODUCTION

> "The development of an African class structure has been mentioned by many writers on modern Africa, but it has not been shown that a true class structure has as yet developed. In fact, we know little about forms of social stratification, whether in Africa or in the remainder of the non-western world." (Middleton, 1970:255)

Although there exists a vast body of literature on forms of social stratification in Europe and, more particularly, North America, there are relatively few such studies pertaining to Africa. The minimal information regarding social stratification in urban areas in Africa, appears to have resulted from the selective interests of anthropologists, who have concentrated on the assimilation of individuals into town life, the processes of urbanisation, rather than the study of the already urbanised and the actual dynamics of urbanism[1]. Stratification concepts such as "class" and "elites" have thus tended to be used with little explicit discussion of their implications, applicability, or even usefulness in the African situation. One can, of course, glean something from such writers as Chodak (1966) and Worsley (1969), who have recently taken critical looks at the class concept with reference to developing countries, and the collection of papers in Tuden and Plotnicov (1970) is a welcome addition to the literature on the subject of social stratification in Africa. The 1956 special edition of the International Social Science Bulletin, together with the collection of papers in Lloyd (1966), represent significant, if pioneering, attempts to refine the concept of social elites for anthropological and sociological usage. In these latter two volumes, however, only Nadel (1956) and Southall (1966) have examined some theoretical aspects of the elite concept.

Middleton (1970:256) comments further that "Studies of elites are

[1] I am using this term in the sense in which Wirth used it, to refer to an "urban way of life".

relatively few". The most recent publications dealing with elites are those of Lloyd (1967 a and b; 1968), Jacobson (1968), Plotnicov (1970), Mair (1971) and Brandel-Syrier (1971). Studies dealing specifically with female elites are virtually non-existent, which fact may reflect the absence of any female elite to be studied. Leith-Ross, for instance, concluded that, at the time of writing (1956), there existed no "feminine elite" in Nigeria, although a tiny number of women might have qualified, individually, for elite status. Fifteen years later, this time with reference to South Africa, Brandel-Syrier (1971:xxv) implies a similar situation when she states that her study concerns "...sixty African male individuals who...constituted the entire social elite of a Bantu township on the Reef..." (In fact, as I shall attempt to show later, Brandel-Syrier's own data would appear to indicate that, of these elites, some were not the men themselves, but their wives.)

In this situation, my own study is intended as a contribution, however small, to the very scanty literature on female elites in Africa; and it also attempts to examine some previously neglected aspects of the elite concept in the light of the contemporary South African situation. It does so by applying the elite concept, as this concept has been developed by Nadel (1956) and others, to a particular category of African professional women who, on the basis of my own and other evidence (for example, that of Kuper, 1965), should be regarded as elites in their own right, rather than as (educated) women deriving high status from their elite husbands.

At the outset, it should be stated that my study represents an "internal view". That is, it is concerned with the light in which African nurses see themselves, rather than with a consideration of how other Africans assess the nurses. Thus I am concerned with the nurses' own self-image, rather than with the community image of African nurses. This concern is, in

one sense, deliberate, since my research was restricted to members of the nursing profession. Nevertheless, it is regretted that resources of time and money did not allow the full-scale community survey which would have been necessary in order to gain a reliable picture of community attitudes towards nurses. However, there does exist some rough guide to community attitudes, in the study of prestige rankings of various occupations, reported by Kuper (1965:436). In this study, the least educated group (primary school children in standard five) ranked the nurse in fourth position on the scale, higher than her sixth ranking by the other three, more educated groups. (The scale included female occupations, but the majority of the occupations, while they could be filled either by males or by females, were predominantly male jobs.)

In view of my lack of data regarding the nurses' position in African society in general, from the points of view of non-nurses and non-elites, I am not really concerned with the wider field of social stratification, except indirectly. This thesis is rather a consideration of why African nurses in South Africa, should be regarded as elites in their own right, on the basis of their professional occupation, corporateness, high status, imitability and general life style, including their attitudes, values and behaviour. The elite status of African nurses in this country has been implied or even explicitly mentioned in some existing literature[1], but nowhere has their position been examined in detail in relation to the elite concept.

The existing data which form the basis for regarding nurses as elites, are qualitative rather than quantitative, as are my own data. Of the general field of one-thousand-odd African registered[2] nurses working in the Durban area, to the majority of whom a very short questionnaire was distributed[3],

[1] See Brandel (1958), Brandel-Syrier (1962, 1971); Wilson and Mafeje (1963); Kuper (1965); Vilakazi (1965); White (1966).

[2] This category exoludes students, auxiliaries and nurse aides.

[3] See Appendix I; and chapter one for details of the distribution of this questionnaire.

less than one hundred and forty were employed at the three hospitals in the Durban area, at which my research was conducted. At the McCord Zulu Hospital, Clairwood Hospital, and St. Mary's Hospital (Mariannhill), I interviewed as many registered nurses as possible, during their off-duty hours, lunch-hours and even tea-times, individually and in groups of varying sizes. The interviews were usually conducted in hospital tea lounges; sometimes in the visitors' lounges of the nurses' homes; and, wherever possible, the interview situation was extended beyond the hospital to the homes of married nurses in the townships (Umlazi, Lamontville and Kwa Mashu) and on the mission station at Mariannhill. (See Map A.)

Interviewing was the main research technique on which this study depended, but direct observation was also possible, particularly in the hospitals. Wherever possible, I attended hospital functions, which included a graduation ceremony, an exhibition of handwork, chapel services, sporting activities, nativity plays and dances. In addition, nearly four weeks were spent observing what occurred in the wards and clinics of McCord's and St. Mary's hospitals and, later, the Charles Johnson Memorial Hospital at Nqutu (Zululand). Although official permission for me to undertake ward observation in the hospitals controlled by the Natal Provincial Administration, was refused, I was shown over Clairwood Hospital when I began research among the nursing staff working there. Thus I came to know fairly well the working situation in which nurses spend nearly one-quarter of their lives as workers. The hospital situation, of course, constitutes an extremely important aspect of nurses' lives, and may be regarded as a "social field" in itself: I did not explore this avenue of research in any detail, however.

I was also able to observe a second facet of nurses' professional lives, by attending meetings of the local (African) branch of the South African Nursing Association, the Ogwini Branch. Fortuitously, too, the

seventh biennial congress (for African members) of the South African Nursing Association, was held in 1970, at the University of Natal Medical School, in Durban. At this congress, I had the opportunity of meeting and talking to African nurses from many different parts of South Africa, who were employed in many different nursing fields.

In addition to the extensive data gained from interaction and discussion with this wide range of informants in professional situations, I collected intensive, detailed life history material from a core of some twelve informants. The total interviewing time spent with each of these informants was in no case less than ten hours, and in one case totalled well over sixty hours. Interesting points often arose in non-interview situations as well, such as visits to market, shopping expeditions, visits to children at boarding school, and while giving "lifts" to nurses on innumerable occasions.

One major gap in my data should be noted, however. I gained very little first-hand information on husband-wife and husband-family relationships, since I was permitted to enter African townships only during normal office hours, when my informants' husbands were, of course, away at work. The data that I do have on family relationships were collected among families residing on mission territory and may, perhaps, be atypical of the family situation of African nurses living in the townships: I have no way of knowing. Particularly in the field of marital and family relationships, then, does my material reflect the "internal view" mentioned above, and the one-sidedness of the resulting picture must be recognised.

In addition to ethnographic data, I have also made use of other material, published and unpublished, which relates to the position of African nurses in South Africa. Legislative and historical material, in particular, has direct relevance to any consideration of the position of nurses as elites.

Hence I do not apologise for the inclusion of material which could, perhaps, be regarded as non-anthropological.

Finally, it should be noted that the present tense used in this dissertation, refers to the situation as I found it to be in Durban in 1970. The Durban situation probably does differ slightly from conditions in other centres, as a result of relatively minor variations in socio-economic factors. However, I have no reason to think that the social position of African nurses in the Durban area differs radically from, or is atypical of, their position elsewhere in South Africa. Local variations in socio-economic conditions and opportunities may affect the structure of the local elite in individual areas and communities, but the general composition of the overall elite stratum in any one country, would seem to be fairly constant. Thus the conclusions reached in this study could probably be applied in South African towns and cities other than Durban, since I have dealt with nurses as part of the overall elite, rather than dealing, as Brandel-Syrier (1971) did, with a particular local elite.

FIELD OF STUDY AND METHODS OF RESEARCH

As I have already mentioned in the introduction, the study on which this thesis is based, involved African registered nurses working in the greater Durban area. The study did not focus on any definable community, for my informants were drawn from three different hospitals in the Durban area (plus one in Zululand, for comparative purposes), and lived in three different townships (Umlazi, Lamontville and Kwa Mashu), in nurses' residences at the hospitals, and on mission territory. Of the total field of approximately one thousand registered nurses working in the Durban area, less than one hundred and forty were included in the reduced field of the three hospitals chosen.

Definition of the Field of Research.

Nursing personnel in South Africa may be grouped into four categories: ward attendants or nurse aides; student nurses; enrolled auxiliary nurses; and registered nurses.

Ward attendants and nurse aides are completely untrained, although they may have gained experience in previous hospital work. Basically, they undertake domestic duties, but they may be required to assist with certain unskilled nursing tasks in the hospital wards. Nurse aides are not subject to the control of the official body governing the nursing profession in South Africa, the South African Nursing Council. In effect, although these aides may sometimes be regarded by the uninformed public as nursing personnel, they are not really part of the profession.

Student nurses may fall into one of two categories, depending on

whether they are training to become auxiliary or registered nurses. Both categories of students are under the control of the South African Nursing Council, and both follow prescribed, standardised courses of training. The general training leading to registration extends over a minimum period of three years, however, and leads to a qualification which is recognised internationally; whereas the auxiliary training is shorter in time, and is geared to providing a supplementary source of nursing personnel to assist the registered nurse, freeing her from routine, semi-skilled nursing tasks so that she may use her specialised knowledge and administrative skills efficiently. The auxiliary training equips the nurse to undertake practical nursing duties, rather than providing her with the detailed theoretical knowledge of anatomy and physiology, pharmacology and microbiology, and medical and surgical specialties with which the general training is concerned.

Enrolled auxiliary nurses, once qualified, may work anywhere within South Africa, but their professional certificate is not recognised in other countries. In fact, the auxiliary certificate has been recognised between different provinces in South Africa only since 1957, when responsibility for this category of nurse passed from the provincial hospitals to the South African Nursing Council, under certain provisions of the Nursing Amendment Act. Because the auxiliary course requires a lower educational standard for admission to training, and because it is of shorter duration than the general nursing course, it has become increasingly important among Africans, but very few White South Africans become enrolled auxiliary nurses. In the words of the South African Nursing Association, auxiliary nurses are "associate members" of the nursing profession in South Africa, and do not have voting rights, at present, on issues concerning the profession.

I chose to restrict the scope of this enquiry to "full members" of the

nursing profession -- to those women who have a minimum qualification of registration as a trained general nurse with the South African Nursing Council. Of over 10 000[1] such African women in South Africa at present, some ten per cent of these are working in the Durban area. In limiting my interest to this category, I have ignored all of the other three categories discussed above, as well as male nurses, of whom there are insignificant numbers. Hence, unless it is explicitly stated otherwise, by the term "nurse", in the remainder of this thesis, I refer to trained, registered, female general nurses.

In view of my limited resources of time and money[2] for this study, student nurses were excluded from consideration because of the possibility that their training might be abandoned before completion, in which case their "junior membership" of the nursing profession is terminated without being replaced by any other type of membership. A fully qualified and registered nurse, however, is recognised as such even if she is not practising as a nurse. Auxiliary nurses were excluded because the qualitatively different training produces a nurse recognisably different from the general nurse. This difference, particularly with reference to Africans, was regarded as being sufficiently important to warrant a full comparative study, which would have been too ambitious for my purposes.

As far as health institutions employing African registered nurses are concerned, there are some twenty-odd hospitals, clinics and tuberculosis settlements for non-Europeans in the greater Durban area. In addition, there are a few non-European doctors in private practice, who employ surgery nurses. I decided to concentrate on the hospitals, since these are the best-known type of health institution. Of the eleven hospitals in the Durban area,

[1] 9 112 as at 31 December 1969: figures supplied by the S.A.N.C.

[2] My bursary was worth R500.00, for one year only.

the McCord Zulu Hospital was selected for primary emphasis, since it is relatively small and easily accessible.

An original supposition had been that nurses trained in different hospitals might display significant differences in attitudes, behaviour and life styles, depending on the type of hospital at which they had trained. Hence a comparative study of a private hospital (McCord's), a provincial hospital (King Edward VIII) and a mission hospital (St. Mary's, Mariannhill), was originally envisaged. However, it became apparent very soon after the research was begun, that this hypothesis did not take into account the factor of mobility among African nurses. The importance of this mobility factor may be judged from table 1[1].

TABLE 1. Number of hospitals at which African registered nurses have worked, including training hospitals, according to age category.

Age Category	Number of Hospitals									
	1	2	3	4	5	6	7	8	9	Total
Under 30	12	16	14	11	4	2	2	-	-	61
30 - 40	17	17	22	22	23	3	1	2	1	108
40 - 50	1	3	10	13	5	9	7	1	-	49
Over 50	-	-	-	-	2	2	1	2	1	8
Total:	30	36	46	46	34	16	11	5	2	226

While it is obvious that the age factor is important when considering mobility among African nurses, it may be seen that a very small proportion (13,3%) of the total number, have worked at only one institution.

Faced with this situation, and with research difficulties at the King Edward VIII Hospital, it seemed logical, at the time, to shift the emphasis of the research to different age categories among the nurses themselves, who

[1] The figures used in table 1 come from a questionnaire used in the course of the research, which will be discussed later in this chapter.

were drawn from different hospitals, namely McCord's, St. Mary's and Clairwood. Aside from differing leisure-time interests and activities, however, remarkably few differences were to be found in attitudes and outlook among nurses of differing ages. It appeared, in the final stages of research in Durban, that the common nursing training imbued nurses from different cultural backgrounds and different age groups, with common ideas and attitudes: in other words, that their identities as nurses were of prime significance, regardless of other factors.

When research in Durban had been completed, I spent some weeks at the Charles Johnson Memorial Hospital at Nqutu, in Zululand, in an attempt to discover whether there exist any significant differences between nurses in town and those in country areas. Not unexpectedly, I found a rather quicker rate of staff turnover at this mission hospital than was found at any of the Durban hospitals studied[1]. A small minority of registered nurses working at the Charles Johnson Memorial Hospital say that they prefer to live in the country, away from the violence and insecurity of township life, but in other respects, I found no differences between country-oriented and town-oriented nurses. Indeed, African nurses themselves say that any differences there may be originally between students from rural, as opposed to urban homes, are usually eliminated by the end of the training period. The rural-urban distinction, and the distinctions based on tribal identity and language, are initial divisive factors that become less and less significant as the students proceed through their training.

Since there are few differences (none of which appear to be significant) based on different training hospitals, age, or town as opposed to rural

[1] Isolated country hospitals, lacking both adequate working and social facilities in most cases, are used by African nurses as "stop-gaps", which afford them temporary employment while they await vacancies at the bigger urban hospitals. C.J.M.H. has better facilities than many country hospitals and, therefore, probably has a lower rate of staff turnover than most others.

background among African registered nurses, it would appear that their identity as educated, professional nurses is so important that it overrides these other (potential) distinctions. Thus the focus of this study finally came to rest on the social identity of African nurses as elites.

The Fieldwork Scene.

Although this study did not involve any particular community (except, perhaps, the "professional community" of nurses), a hospital is, or can be, a relatively self-contained community in itself, particularly if it is geographically isolated. Even in large cities and towns, however, a hospital may be regarded as a distinct social field, with possibly unique characteristics. The nurses I studied spent roughly one-quarter of their total time[1] actually working in the hospitals. Some of their off-duty hours were also spent at the hospitals (for instance, on days when they worked split shifts with a couple of hours off in the afternoon). Some, of course, actually lived at the hospitals, in the nurses' residences. The hospitals obviously constitute a significant aspect of the nurses' total lives, for not only is the hospital the work-place, it is also the focus of their identity as nurses. A short discussion of some of the identifying characteristics of the hospitals at which I did a large proportion of my research, is thus important. (See map A for the localities of these hospitals.)

(a) McCord Zulu Hospital.

The Mission Nursing Home (as it was first called) was opened in 1909,

[1] Nurses officially work a forty-hour week, and there are one hundred and sixty-eight (168) hours in each week. Thus, apart from her annual leave, the nurse is occupied, for approximately one-quarter of the hours in each week, in her hospital job.

after a lengthy legal battle, which ended in the Supreme Court of Natal, had finally overcome opposition to the building of a non-European hospital on Durban's Berea ridge[1]. The twelve-bed hospital was the personal financial liability of Dr. James McCord, an American missionary doctor, and it was the first hospital in Durban to cater exclusively for the needs of the African population. From the start, it was intended to serve the Zulu people from all over Natal and Zululand, and one aspect of its service role was the training of African personnel in aspects of western medicine. Although plans for the training of medical aides, and later, doctors, were largely unsuccessful, the training of nurses began immediately, though not without difficulty.

> "To find even three Zulu girls willing to study nursing had been difficult enough, for none in all South Africa had ever trained for that career before. They were as wary as their parents of any path not worn deeply by other native feet." (McCord and Douglas, 1951:181)[2].

Nursing training began in 1910, but until 1924, when the bed capacity had been increased and other facilities improved, it was not recognised as being of sufficiently high standard to enable the nurses to become registered with the Colonial Medical Council. Midwifery training was also commenced in the early nineteen-twenties, and the Mission Nursing Home had the distinction, in 1927, of producing the first doubly-qualified African nurse (in general nursing and midwifery), in South Africa.

The World Depression of 1929-32 affected the hospital drastically, since the American Board of Missions (which had taken over the hospital in the early nineteen-twenties), could no longer support it financially. In 1931, a Hospital Advisory Board was constituted, and suggested that the hospital become independent of the parent mission body. Accordingly, the Advisory

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[1] The future of this non-European hospital, in a White residential area, remains somewhat uncertain even today, some sixty years later.

[2] McCord's statement that no other Africans had trained as nurses is not strictly true: see chapter three of this thesis.

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Board became a Board of Management when the American Board of Missions agreed to relinquish its property rights to the valuable hospital site, as well as its financial responsibility for the running of the hospital. A constitution was drawn up, and the Mission Nursing Home became the McCord Zulu Hospital, with its affairs controlled by its Board of Management (which was, and still is, constituted from among prominent local citizens of different races).

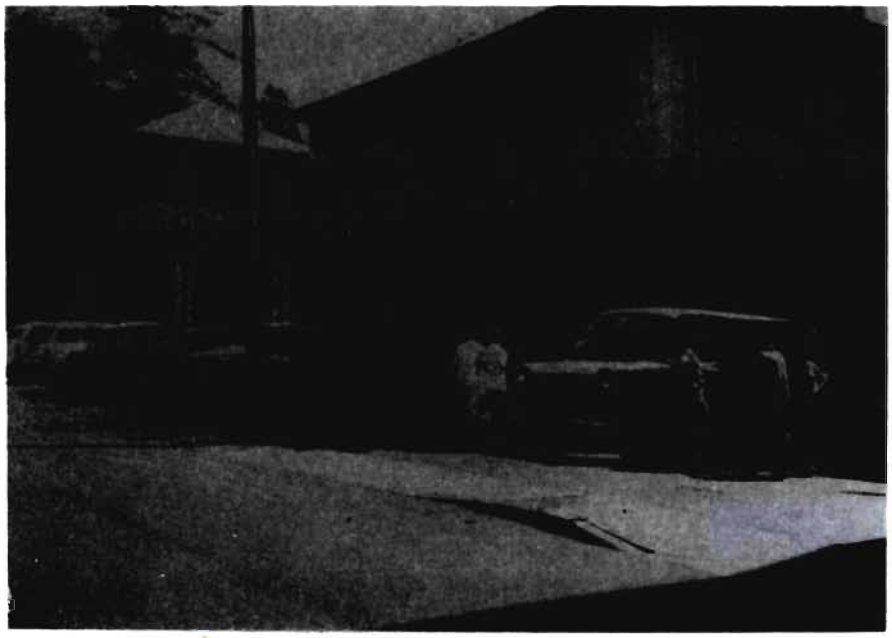
From its very modest beginnings, the McCord Zulu Hospital has grown to be an important modern hospital, of considerable significance within the structure of non-European health services in Durban. In 1970, McCord's had approximately three hundred beds, and employed thirty-five African registered nurses as sisters and staff nurses; plus thirty-six student midwives; and over one hundred and forty general nursing students, in normal circumstances. McCord's has gained fame as an exceptionally good nursing school, and draws some of its students from far beyond the borders of South Africa. No doubt its attraction stems partly from the policy adopted at the beginning:

> "From the time the Mission Nursing Home started to train native nurses, we gave them training equal to that received by White probationers." (McCord and Douglas, 1951:280)

During the period of my research, McCord's was undergoing another crisis period in its history. As a result of the recently raised entrance requirements for general nursing students[1], it appeared that the hospital would have to abandon the training (leading to registration as a trained general nurse) that it had offered since 1924. The hospital authorities considered that they were unlikely to receive sufficient applications to fill the student vacancies, because so few African girls (can afford to) proceed beyond the Junior Certificate in their schooling. It also appeared

[1] Published in the Government Gazette, no. 3792, of 28 November 1969. See chapter three of this thesis for a discussion of these revised requirements.

PLATE I.



(a) McCord Zulu Hospital. Behind the older hospital buildings shown here, is the five-storey main block.

(b) St. Mary's Hospital, Mariannhill.

unlikely, in view of the less-than-ideal working conditions (hours, facilities, equipment and pay), that the hospital could hope to attract suitably qualified nursing tutors to teach the revised syllabi. It was, therefore, decided to discontinue the general training in favour of auxiliary training, for a trial period beginning in 1970. The decision pleased no-one. Within months, it had become clear that the hospital could not be staffed adequately with students undertaking the auxiliary training: the level of knowledge imparted in this course had proved too superficial in relation to the responsibilities students were expected to assume. Thus it was decided to recommence the general training:

> "This step has been taken in faith, for as yet we do not have a full tutorial staff, and we do not know whether a sufficient number of applicants will be forthcoming now that the entrance qualification has been raised."[1]

(b) St. Mary's Hospital, Mariannhill.

St. Mary's is officially slightly smaller than McCord's, having approximately two hundred and forty beds, and employing eighteen lay African registered nurses. Like McCord's, St. Mary's is a training school for both general nurses and midwives, and began training African students shortly after the hospital was opened in 1935. St. Mary's is controlled by the Catholic order of the Sisters of the Precious Blood, most of whom are of German nationality.

Mariannhill Mission is situated some three miles south-west of Pinetown, roughly eighteen miles from the centre of Durban. The mission is largely self-contained, and comprises the convent and monastery, two guest houses, St. Joseph's Cathedral, St. Mary's Hospital (which has a small

[1] Medical Superintendent's Annual Report, 1970:6.

European wing accommodating some thirty patients), a series of educational institutions catering for nursery-school children through to matriculation, and a vocational school specialising in carpentry and book-binding. In addition, the weekly publication umAfrika is printed at the mission; and fresh milk and vegetable requirements are supplied from the mission farm for sale to members of the mission community, most of whom are African nurses, teachers and clerks (apart from members of the religious orders).

St. Mary's trains not only lay nursing students, but nuns as well, and the "religious" students comprise some twenty-five to thirty per cent of the total intake. Senior nursing positions are filled by members of the religious order, so promotion is effectively blocked for the lay trained nurses. The atmosphere of the hospital is restrained, even austere, and the discipline to which the students are subjected is rigorous. Most of the students are themselves Catholic, and in general, they are somewhat older than those at McCord's, since many of them have completed the auxiliary training before commencing general nursing. A majority of the registered nurses is also Catholic.

In general, St. Mary's appears to be much more compact and isolated, and is quieter, than McCord's. Even though it is less than an hour's bus journey from Durban, St. Mary's has the feel of a rural establishment -- quiet, conservative, somewhat strait-laced. However, some attempt is made to meet the social needs of the staff: a swimming pool and tennis court are available at certain times for the use of the nursing staff, and the occasional film is shown. But the main emphasis is on church attendance and religious commitment.

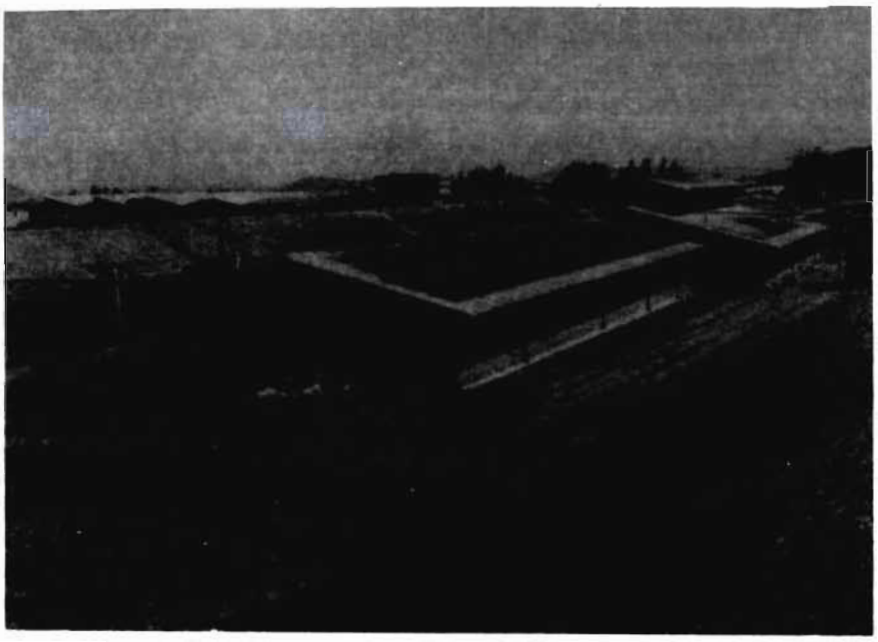
(c) Clairwood Hospital.

Situated in the industrial area of Mobeni, south of Durban, Clairwood Hospital is controlled by the Natal Provincial Administration. Clairwood used to be a military establishment, and the barracks have been converted into wards, each of which accommodates some fifty-odd patients. All told, the hospital has approximately nine hundred and forty beds in use at present, and employs some ninety African registered nurses in posts for staff nurses, sisters and assistant matrons. Although the hospital has its own Outpatients section and does admit serious cases directly to its wards, it is basically a convalescent hospital serving the King Edward VIII Hospital, in Umbilo.

With the exception of an operating theatre, Clairwood has all of the departments that McCord's and St. Mary's have -- medical, surgical, tuberculosis, paediatrics (children) and maternity -- on a very much larger scale, but, unlike the others, Clairwood does not undertake nursing training of any description. Most of the nursing staff are auxiliary nurses and nurse aides, in contrast to McCord's and St. Mary's, where students comprise the majority of the nursing establishment. Of the three Durban hospitals I studied, only Clairwood had posts for African (assistant) matrons and thus, along with other provincial hospitals, held out the best prospects for promotion, for African registered nurses.

Clairwood Hospital has been in existence only thirteen years. Prior to 1958, the site currently housing the hospital, was occupied by the Institute of Family and Community Health, a multi-disciplinary body concerned with social and preventive medicine, which is now defunct.

PLATE II.



(a) Clairwood Hospital, situated in the Durban industrial area of Mobeni.

(b) Charles Johnson Memorial Hospital, Nqutu, Zululand.

(d) Charles Johnson Memorial Hospital, Ngutu.

Formerly controlled by the Church of the Province of South Africa (Anglican), what was a seven-bed cottage hospital in 1945, now has nearly four hundred beds, officially, and usually has up to six hundred patients. During this period, the hospital's development has been guided by the medical husband-and-wife team who run the hospital and who have made it their life-work. The nursing staff establishment (which was under review by the Department of Health at the time of research) included approximately forty African registered nurses, some forty student midwives, and roughly one hundred and forty general nursing students.

Auxiliary nursing training began at the Charles Johnson Memorial Hospital in 1948. This four-year training included midwifery, but it qualified the nurse for recognition only within the borders of Natal, until the Nursing Act (Amended) of 1957 brought the auxiliary training within the province of control of the South African Nursing Council.

Training under the S.A.N.C. syllabus for general nurses was begun in 1961, while the older auxiliary training was phased out by the end of 1964. Midwifery training was continued, however. Approximately one hundred and twenty general nurses have trained at the Charles Johnson Memorial Hospital since 1961. However, the recently revised entrance requirements for the general nursing training, have affected C.J.M.H. in much the same way as these have affected the McCord Zulu Hospital. The plan at C.J.M.H. is to train general and auxiliary nurses concurrently from 1971, taking one group of trainees for the general course each January, and one group for auxiliary training each June. The hope is that, in the future, the auxiliary-trained nurses will proceed to the general diploma course. Rural training hospitals,

such as the Charles Johnson Memorial Hospital, attract few well-qualified applicants for training: on average, less than ten per cent of the students at this hospital have been matriculants. Since a standard ten pass, or else enrolment as an auxiliary nurse, is now required for the general training, the alternation of general and auxiliary training courses is the only way in which such hospitals can hope to continue the higher-level training.

The Charles Johnson Memorial Hospital has recently undergone a change in status. On April 1st, 1970, the Department of Bantu Administration (central government) assumed financial responsibility for all mission-controlled hospitals located in the Bantu Homelands and also for some, like the Charles Johnson Memorial Hospital, that are not strictly on tribal land. (Nqutu is a "white spot".) This change means that the Department of Bantu Administration, working through the Department of Health (also central government), will pay the salaries of all staff on the approved establishment, but will not, as far as is known, interfere with the functions of the boards of management of the individual hospitals[1].

It is interesting to note that, while McCord's senior staff expected that financial responsibility for their hospital would be assumed by the Department of Bantu Administration, in the same way as occurred at the Charles Johnson Memorial Hospital, this never materialised, thus raising further doubts about the future of the McCord Zulu Hospital.

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[1] The assumption of financial responsibility for mission hospitals is part of a wider plan to extend and co-ordinate health services in the rural areas. The decentralisation policy, whereby each defined geographical area will be served by one large hospital, which will control and staff a number of sub-stations (each having three or four beds, for emergency and possibly convalescent treatment) and many clinics and medicine depots, is intended to ensure that no-one in that particular area is more than a few miles from skilled medical attention. This decentralisation policy bears considerable resemblance to Russian health services. Obviously, because of the shortage of qualified (African) doctors in South Africa, the registered nurse is a key figure in this plan.

Comparisons and Contrasts among the Four Hospitals Studied.

Modern nursing traces its descent from the ethic of charity among the early Christians, but the extent to which the Christian ethic is emphasised and enforced, varies at different hospitals. Adherence to Christian, and specifically Catholic doctrine, is enforced most strongly at St. Mary's (of the four hospitals covered during the course of this study). All students at St. Mary's are required to attend religious services at least once daily, and although the trained nurses are not forced to attend church with such regularity, they are expected to set an example to the students. At the Charles Johnson Memorial Hospital, in contrast, everyone (including the student nurse) is free to make an individual decision regarding church and chapel attendance[1]. At McCord's, there is no compulsion on registered nurses to attend chapel services, but students are ordinarily required to attend the (very informal) Sunday evening services, which are held in the Nurses' Home. Neither McCord's nor Clairwood have chapels, but in each case one room in the nurses' home has been set aside for use as a chapel, where interdenominational services, conducted by visiting ministers, are held at regular intervals.

One striking contrast between Clairwood and the other three hospitals is that Clairwood, although by far the largest, does not undertake any kind of nursing training. McCord's, St. Mary's and Charles Johnson Memorial hospitals are all recognised training hospitals for both general nursing and midwifery. Hence the work problems faced by qualified nurses working at Clairwood, are somewhat different to those faced by registered nurses working at training hospitals. African registered nurses regard auxiliary nurses and nurse aides as being difficult to work with, less responsible, more stubborn

[1] This policy is not characteristic of mission hospitals in general.

and slap-dash in their work than are students, because there are no examination or promotion incentives for semi- and unqualified nursing personnel.

At all four of the hospitals studied, the registered nurses on their staffs come from diverse tribal and home backgrounds, and have trained at many different hospitals. Tribal diversity among the registered nurses is most marked at Charles Johnson Memorial and St. Mary's hospitals, and perhaps this diversity is a result of their rural localities: I have already mentioned that the isolation of rural hospitals results in a rapid rate of staff turnover, since the jobs are regarded as temporary.

Any attempt to rank these four hospitals in terms of their prestige in the eyes of African nurses, would have to take into account a number of cross-cutting factors. McCord Zulu Hospital is a renowned training school, but salaries at Clairwood (a provincial institution) are more attractive, even though working relationships are regarded as being more difficult. Particularly for those nurses living in Lamontville, however, Clairwood is extremely convenient in being, at most, twenty minutes' bus journey from home. St. Mary's has the advantages of a rural location -- including staff quarters on mission territory -- and yet it is within easy commuting distance of Durban, for shopping and entertainment purposes: but salaries are lower than those on provincial scales. Charles Johnson Memorial Hospital has what is probably the single greatest disadvantage in its truly rural location, because the majority of African nurses are urban-oriented, and relatively few are willing to stay in the country on anything more than a temporary basis. Again, salaries are lower than those on provincial scales. However, the Charles Johnson Memorial Hospital is well-known and respected by African nurses, (and doctors), on account of its ethic of non-racialism,

which is practised as well as preached. This factor alone, in South Africa, gives it a positive rating despite its other disadvantages. Furthermore, C.J.M.H. makes great efforts to cater for the social needs of its nursing staff, and maintains regular contact through sport (especially tennis) and music and dancing, with other hospitals as far afield as Pietermaritzburg and Empangeni, and with the University of Zululand at Ngoye. There is far more social activity at the "Charlie J" than at any of the other hospitals, and life is rarely dull, despite the hospital's rural isolation.

Research Methods.

It was apparent, even before research was begun, that I would have to deviate from such "traditional" techniques of anthropological enquiry as participant observation, since I was undertaking urban research within the framework of South African society. Not only could I not live among my informants, but it was not even possible to visit respondents living in African townships, after normal office hours, because the terms of my permits did not allow this. Hence opportunities for direct observation occurred in the hospitals, among families living on mission terrriory, and, to a limited extent, among informants living in the townships, who were sometimes at home during the periods in which I could visit them.

Open or unstructured interviewing and general conversation thus proved to be the essential techniques on which my research depended. Informal discussions, as well as the collection of life history and genealogical material, were dependent on regular interviews with a core number of some twelve individuals, and intermittent interviews with most other nurses working at the three Durban hospitals. Since all of my informants were perfectly fluent in English (their entire nursing training is done in this language or, less frequently, Afrikaans), there were no problems regarding

communication, and I did not need the services of an interpreter at any stage. Indeed, I feel that the presence of a third person at many of these interviews would have proved a hindrance rather than a help, since African nurses are reticent about discussing their private affairs with their colleagues or anyone else. Particularly an outsider from their own racial group, would have upset the balance of confidence to the detriment of my research. However, it would probably have proved useful to employ an assistant to undertake research into home life that I could not do myself: unfortunately my rather slender financial resources did not permit this.

Statistical Information.

The collection of statistical data posed certain additional problems. Although I was given access to staff records at McCord's (for students and trained staff) and St. Mary's (for students), the Natal Provincial Administration authorities refused to allow me to consult any provincial hospital records, despite (additional) requests by the medical superintendents of Clairwood and King Edward VIII hospitals, that I should be allowed to consult non-confidential records.

In order to overcome this serious disability, a short questionnaire[1] was compiled and distributed to African registered nurses working at the following health institutions: King Edward VIII, Clairwood, Wentworth, Point Non-European, King George V, Umlazi Mission, McCord's and St. Mary's hospitals; the Umlazi and Kwa Mashu Polyclinics and the Durban City Health clinics; the Botha's Hill Tuberculosis Settlement; and to industrial nurses working for the Public Utility Transport Corporation. Four other health institutions were omitted as a result of non-co-operation on the part of the controlling authorities; and no attempt was made to contact the very

[1] Mentioned previously: see Appendix I.

small number of registered nurses working in doctors' private surgeries. Copies of this questionnaire, with its accompanying letter of explanation and stamped, addressed envelope, were distributed to nine hundred and thirty (930) African registered nurses, two hundred and twenty-six (226) of whom returned completed forms -- a return rate of 24,3%.

The use of a postal questionnaire has not, to the best of my knowledge, been a common method of anthropological enquiry in the past. In this particular instance, however, it was the only way in which I could possibly acquire the information needed and, to the extent that this was achieved, I consider that the use of the questionnaire was justified. It was fortunate that nurses are both literate and quite familiar with the European habit of collecting information by means of standardised forms; and that the network of members of the local African branch of the South African Nursing Association, the Ogwini Branch, was available to remind colleagues to complete and return the questionnaire forms.

Research Difficulties.

My major difficulties have been discussed already: the refusal of the Natal Provincial Administration authorities to allow me access to hospital records; and the restrictions placed upon my movements in the African townships by the terms of my permits. Difficulties of a less serious nature arose fairly frequently with the last-minute alteration of off-duty times of informants, which usually resulted in cancelled or abandoned appointments. While it was usually possible to substitute respondents by interviewing whoever happened to be available, the cancellation of an appointment with an important informant usually entailed waiting at least one week before another suitable time could be found, hence a fair amount of time was,

perforce, wasted, in a sense.

A Note Regarding Identity.

Finally, a point of identity requires mention. In addition to my anthropological training, I am myself a qualified nurse, having completed the Bachelor of Social Science (Nursing) degree of the University of Natal, in 1968. During my training, I had become aware of the hostility that is often harboured by non-European nurses towards their European counterparts: hostility that is a result both of differential salaries and of the legal provision that a non-European nurse may not exercise authority over a European, even if she holds equal or higher qualifications. I therefore deemed it wiser not to reveal a qualification which I have never used nor intend to, and this assessment was reinforced during the course of my research. The automatic assumption that I was not involved in the world of nursing -- which, then and now, was and is correct -- was, I think, one of the reasons for the African nurses' wholehearted acceptance of my enquiries, and willing co-operation. The possibility that I might be a nurse was, fortunately, never raised.

At the same time, however, my personal knowledge of the nursing world was essential in assessing what went on in the hospital wards, the quality of the nursing service, normal and abnormal hierarchical relationships, and so on. Furthermore, my knowledge of hospital life equipped me with a basis for comparing African hospitals with my own experiences at Addington Hospital, in Durban, where the practical aspect of the nursing degree required that I work for four years. I hope that this experience did not impair too seriously my objectivity in observation, for my awareness of such a possibility should have minimised it.

In conolusion, I should perhaps remark that, contrary to the reported experiences of some anthropologists[1], my respondents did not regard my investigations with amazement, incredulity, suspicion or any of the other apparently standard reactions. They were interested, not only in the reasons for the study itself, but in the whole field of anthropology. In fact, I was invited to deliver a short address to members of the Ogwini Branch on the subject of anthropology. Some of these nurses had personal knowledge of anthropologists (some were related to, or knew, Zulu anthropologists who have trained at the University of Natal). Some had read anthropological writings. Some would have made good anthropologists themselves!

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[1] See, for example, Geddes, W. R. 1957. Nine Dayak Nights. Oxford University Press Paperbacks, New York. p. xii; and Beattie, J. 1965. Understanding An African Kingdom: Bunyoro. Holt-Rinehart, New York. p. 14.

CHAPTER TWO

THE CONCEPT OF ELITES IN MODERN AFRICA

The bulk of this thesis is concerned with an analysis of my research data in terms of the elite concept. Before attempting to show, in detail, why African nurses should be regarded as part of the modern elite stratum, however, I wish to consider, again in some detail, the theoretical implications underlying the concept of elites, as this concept has been developed by Nadel (1956) and refined by Lloyd and others.

Differing Uses of the Term "Elite".

In one common usage, the term elite refers to the elect, the aristocracy. This usage has connotations of excellence in achievement, yet, paradoxically, smacks of an hereditary establishment. Elite is seldom used in daily conversation, however, perhaps as a result of the declining importance, in our own society, of hereditary systems of government and social class. The term elite is now mostly used among specialists, particularly political scientists and sociologists.

Pareto (1935) was one of the first to adapt "elite" for sociological usage. He used it to refer, firstly, to those persons in any particular group who could be rated, in terms of achievement, above their fellows; and secondly, to the governing class. Elaborating on Pareto's work, Mosca (1939) developed more fully the concept of a ruling elite. Despite these early attempts to refine the use of the term, however, looseness in terminology has persisted among sociologists. Provided one indicates, in broad terms, how one intends using the term "elite", it seems to have become common

practice to use it almost as one likes.

More recently, then, one finds that the elite concept has been taken over by social anthropologists working in the politically emergent states of Africa, and they have used "elite" to refer to those indigenous persons who have broken away from the traditional structure of their society -- the literate, and the highly educated.

It is, therefore, not surprising, in view of the many differing and diffuse uses of "elite", that the whole concept of elites has become confusing and ambiguous. It is possible, though, in the past, that part of the value of the term has lain precisely in its vagueness, as Nadel (1956:414) believes. The following sections of this chapter will attempt to discuss and, perhaps, make more definite, some of the more important features of elites in modern Africa.

Definitional Features of Elites in Modern Africa.

The first, very obvious point to be made, is that the elite category must incorporate a plurality of persons, and this "stratum of the population" (Nadel, 1956:413) is more or less organised into an identifiable group or quasi-group. A single individual may have elite status, but he or she cannot, alone, constitute an elite. Although the elite stratum comprises a number of individuals, however, the total number is usually a very small proportion of the total population, and elites thus constitute a minority group within the society as a whole.

Secondly, elites must be aware of their own identity as elites, and of their position as a high-status group. As Nadel (1956:415) puts it:

> "...elites, as here understood, must have some degree of corporateness, group character and exclusiveness...they must form a more or less self-conscious unit within the society, with its particular entitlements, duties and rules of conduct in general."

As a third consideration, admission to the elite stratum must be restricted: "...there must be barriers to admission..." (Nadel, 1956:415). The ways in which admission is restricted, however, would appear to vary. In modern Africa, the restriction has resulted primarily from limited opportunities in the field of education. Thus while the requirements for entrance to the modern African elite are, theoretically, open to anyone, restricted opportunities have effectively closed the elite stratum almost as tightly as does any explicit restriction on the admission of new personnel by members of the existing elite, jealously guarding their privileged position. Explicit restrictions on entry are, of course, found in the professions, but it is usually open to anyone to try to attain professional qualifications. It is the generally low levels of education and the restricted opportunities for acquiring it which have, in the past, caused the elite stratum in Africa to be partially closed. The modern African elite is not closed in a manner comparable to some of the European aristocracies prior to the French and Industrial Revolutions, however. Rather, the African elite is a partially closed collectivity in an opening society, and is itself part of the modernising process.

In noting the partial closure of the elite stratum, I have implied a fourth criterion of elite status: that is, that the attainment of such status is dependent upon the possession of certain acquired skills and attributes. The modern elite is not based on ascribed status, and will, therefore, be found only in a society that is open or opening. By definition, then, the use of the term elite to refer to persons filling ascribed

positions in traditional society, is inappropriate (or at least different) unless there is some minimum measure of openness manifested in competition for position, such competition being based upon acquired skills. To write of the "tribal elite" or "traditional elite" when referring to persons holding positions of authority in the traditional political systems of modern African states, as Busia (1956), Ngcobo (1956) and others have done, is to use the term elite in a different sense from that which it has acquired in its modern anthropological context. Such usage confuses the governing elite of Pareto and Mosca with the modern usage, which refers to an anti-traditional minority group, members of which have influence because of their successful, though not necessarily total, adaptation to a different and dominant culture.

Because elite status is dependent upon achievement, and because admission to the elite stratum is restricted largely on the basis of occupational qualifications, the elite category as a whole is composed of a number of sub-groups, or perhaps status-groups, which are based on occupational distinctions. Some occupations, such as clerical jobs, carry a general educational requirement; most professions admit only specifically-trained personnel. In modern Africa, the allocation of such occupational categories to the ranks of the elites, has often caused confusion, for what may be regarded as an elite occupation in one country may not be regarded as such elsewhere, as a result of differing overall levels of education. But however much these may differ from one country to the next, there nevertheless exist certain minimum qualifications for elite recognition in all countries.

In passing, it should be noted that the practice of defining, on the basis of occupation, who may or may not be among the elites in developing countries, has another serious drawback, since changes may occur in the ranks of the elite with the advent of new economic and political factors. In

developing a country's economy, for instance, new jobs may be created and assume immediate importance in the occupational structure: highly skilled technical occupations have recently assumed importance in Africa, for example, where previously these had not existed. When such economic changes occur, occupations which were previously highly rated, may lose much of their importance, particularly in a relative sense. Thus changes in the economic structure of a society may open up new elite occupations, while causing others, previously important, to become somewhat redundant, and lose prestige. Political changes may cause similar shifts: the relinquishing of political power by colonial governments, for instance, has brought into prominence a new political elite in Africa, based on power rather than advanced education and/or wealth. And, in very recent times, the military establishment in African states has emerged as a powerful factor in politics as well. As Southall (1966:348) notes:

> "...an elite taken as a whole is a dynamic category rather than a group".

To return to the identifying characteristics of elites in modern Africa particularly, the final and perhaps crucial factor is their high social status and prestige, or what Nadel (1956:417 ff.) terms their "generalised superiority", which gives rise to their imitability. This social superiority is quite distinct from the power, or authority wielded by a governing elite, though the two are frequently found in association. The high social status of elites is partly a result of their achievement in meeting the entrance requirements for admission to the elite stratum (what Nadel (1956:418) terms "preconditions" for elite status); but it is also related to the elites' influence as a result of their position as a general reference group in the wider society (what Nadel (1956:418) calls the consequences or concomitants of this status). The preconditions for elite

status are not normally imitable, but some of the concomitants of this status are. Thus the elites' manners and morals, life styles and interests stand as models to be copied by the society at large.

The imitability of the elites may extend beyond the material plane. Their power of innovation may, in fact, include change within the value system itself of the culture in question. Insofar as elites in Africa are actively promoting a new, western-based standard at the expense of the traditional culture, they are indeed attempting to alter the structure of values within their societies. In fact, the elites may well regard themselves as having an educative function in promoting the new cultural standard among non-elites.

However, where at least two basic cultural standards are in operation, as occurs in the changing societies of Africa, the cultural pattern represented in the lives of the elites may <u>not</u> be considered imitable, or even desirable, by the section of the population which is still positively committed to the traditional culture. For these people, the elites represent <u>not</u> a reference group for standards, values and behaviour, but rather a culturally deviant sub-group. In such a situation, what acceptability the elites have among this section of the population, will derive from their political and economic power rather than their "generalised superiority" in the social sphere.

Of course, as Nadel (1956:418) does indicate, not all of the qualities of elites can be equally imitable, especially those characteristics which actually confer elite status. It happens, then, that certain material possessions, such as clothes, furniture and motor cars, become symbolic of the achievement of elite status, and conspicuous consumption becomes apparent

among those who strive towards identification with the elites. The model of the elite life style that is presented to the population at large, is often unrealistic, and usually unattainable by those seeking elite status, but, far from invalidating the model, this situation merely emphasises the superiority of the elites. The gap between elites and non-elites in terms of their respective standards of living, is all the more noticeable in that it has arisen in societies where, in the traditional past, some measure of egalitarianism prevailed. As Lloyd (1966:12-13) indicates, in the situation where elites have incomes at least ten times those of the working masses, the "sub-elites" (those on the fringes of elite status) may be the more significant reference group in practical terms, for the masses. The lower incomes of these sub-elites result in a life-style that is "scaled down" from that of the elite proper, and is thus more open to imitation.

Having discussed the important general identifying characteristics of modern African elites, I now wish to discuss why, in Africa particularly, the elite concept has been and still is used in preference to analysis in terms of social class.

The Elite Concept in Relation to Social Class.

In Africa, where radical social and cultural change has already occurred and is still progressing, at least two distinct cultural standards may be identified. There are the "traditional" sets of norms and values, and there are those which have resulted from contact with the different cultures of western Europe. In earlier times, these two cultural standards were polarised: European colonists and expatriates exhibited the western pattern, while the vast majority of Africans continued their traditional ways with little modification. Between these two groups, however, there arose a small but

significant intercalary group, the so-called "African middle class", members of which, although they could not be regarded as wholly western in culture, were nevertheless far removed from the traditional background of their fellow Africans. These évolués were the products of the early mission schools in Africa, and were educated in the British or French traditions. They formed a focal point in communication between European and African, and were seen as occupying a social position somewhere between that of the governing European elite, and that of the bulk of the African population: hence the term "middle class". While their position was, in many respects, sociologically marginal in that they were never identified as belonging wholly to either major section, these évolués became trained and skilled participants in the new money economy, thus deriving greater material benefits than their uneducated fellow Africans. In turn, their children benefited in similar manner. Today, the elite descendants of these early évolués usually fill highly skilled technical and professional positions, and have moved still closer to the western cultural pattern.

The modernisation process is reflected not only in the occupations of the elites, however, but in their life style, interests and leisure pursuits as well. Expensively furnished houses; well-cut clothing; privately-owned motor cars; boarding school education for the children; membership of orthodox, status-giving churches -- all are indices of elitism in modern Africa. The interests and activities of the elites are made possible by their relatively high incomes (which in turn are related to their occupations), and their expenditure patterns reflect the wide discrepancy between their own values and those of the non-elite, traditionally-oriented masses. Thus the elites are distinguished from non-elites both in structural and in cultural[1]

[1] Mayer (1963:6) has discussed the distinction between structure and culture in some detail, with reference to the process of urbanisation. My own interest lies in the relevance the structure/culture distinction has for the wider process of modernisation, without a specifically urban referent.

terms. As will be shown later, for African nurses in particular, social relationships and roles, as well as occupation, are some of the means whereby elites differentiate themselves from non-elites; but equally well, some very important distinctions between elites and non-elites depend not on these structural aspects, but on the cultural aspects of values, attitudes and behaviour. While structural differentiation is important, the distinctions based on culture are perhaps more striking when one looks at African elites against the background of African non-elites.

The high status and prestige which characterise elites in Africa, result from their ability to manipulate and work within the new and dominant cultural pattern based on the western model, which ability in turn is closely related to occupation. The occupational structure, of course, rests on economic development, which is regarded, particularly by the elites, as vitally necessary in African states. Yet few Africans have been prepared to cope with the new world of urban, industrial technology, and occupational specialisation, which economic development entails. The elites, however, not only work within the modern framework: insofar as they fill key administrative, technical and professional posts in the modern structure, they in fact control it, and it is on this basis that their prestige and high status rest. The elites are actually <u>outside</u> the traditional framework, even though they retain links with it, for example, through kinship ties.

While traditional and modern structures continue to be found in association with differing cultural frameworks; and while two (tradition-based and modern) cultural patterns continue to exist simultaneously within a single overall social structure (that is, the modern state) -- is it really permissible to consider analysing the position of any section of the total society in terms of the class concept? One may talk, of course, as

sociologists dealing with Western societies have done, of the sub-cultures of different classes. Such sub-cultures are, however, merely variants on a common cultural theme. But when one encounters two (or more) distinct groups or populations, each having a distinct and separate culture, can one legitimately regard these groups as two (or more) different social classes within a single social system? I think not. Some current terminological problems have arisen from precisely this source of confusion in the past. The "African middle class", for instance, earned this mistaken appellation because certain individual Africans were seen to be somewhat different, culturally, from the majority of the indigenous population, and could thus be regarded as a kind of buffer group between European and African. It seems unlikely that the normal criteria of class identification,

> "...including income, occupation, accent, spending habits, residence, culture, leisure pursuits, clothes, education, moral attitudes and relationships with other individuals... (plus) a look at (the individual's) family, including the generation of his parents, himself and his children..."[1]

were applied systematically when individual Africans were assigned to the "African middle class". The term "middle class" was really a convenient shorthand reference to Africans who did not fit into the European stereotype of "African": and today's social scientists are still trying to unravel the confusion that has resulted from this misuse of the class concept. The issue of cultural difference, in modern systems of social stratification in Africa, remains crucial.

Although there is evidence to suggest that the educated stratum of one generation contributes a significant proportion of potential elites to the next generation (because educated parents educate their children), it would

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[1] Quoted from Lewis, R. N. and Maude, A. 1949. The English Middle Classes Pelican Books, Harmondsworth. Since the original was not available, I have re-quoted from Mitchell, J. C. (1956).

appear that a majority of today's elites come from traditional home backgrounds[1]. There is no evidence to suggest that a semi-closed and self-perpetuating "educated class" exists in African countries today. As Plotnicov (1970:269) indicates:

> "In the view of many scholars it would be premature now to speak of the existence of social classes in Africa".

However, if any group in Africa does begin to approximate a social class, it is the elite stratum, for elites have been reported to manifest something resembling class consciousness in their behaviour and value systems. Plotnicov (1970:271) opts for the view that African elites do form a single social class, despite the admitted lack of other classes; that elites are the focus around which a class system is beginning to crystallise; and that an incipient middle class, of lesser status than the elites, but striving for identification with them, is identifiable; and that the bulk of the population "...as a residual category, will continue to form the base of the pyramid" (Plotnicov, 1970:300). Plotnicov would, I think, agree with Ardener (1967:64) in his view that "...the elite concept in the social anthropology of Africa is near the end of its period of scientific usefulness".

However, Plotnicov (1970:274 and 292) also points to the cultural gulf between elites (and those striving toward elite status) and the bulk of the population. He states that:

> "People in Jos have no difficulty determining whether an individual is a traditionalist or a modernist for the cultural indications are many and clear..."
>
> "...in Jos, part of the population seeks to identify with the modern African elite and strives to be accepted into

[1] Clignet and Foster (1964:357), for instance, dealing with samples of secondary-school students in Ghana and the Ivory Coast, note that "...these systems...recruit from very broad segments of the population...almost 70% of Ivory Coast students and nearly 40% of Ghanaian students come from farming families in which parents are overwhelmingly illiterate".

> its ranks. This is, of course, untrue for most of the population, who sorely lack even a modest amount of modern elite qualifying attributes, and who adhere to traditional systems of prestige."

Thus, while I am in complete agreement with Plotnicov (1970:300) when he states that African countries can be expected to develop class systems as their economies undergo modernisation, I do think that class analysis remains inappropriate at present. Not until further socio-cultural change has effected much greater cultural homogeneity in the total populations, to replace the existing heterogeneity between modern and traditional outlooks, will the concept of social class be able to add more to our understanding of modern African social systems, than the elite concept[1]. This is so because the high status and prestige of African elites result from their ability to work within a modern cultural framework based on that of the West.

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[1] Brandel-Syrier (1971:xxvii and xxix) has also objected to the use of the class concept, in her discussion regarding the position of African elites. Her argument would appear to be that the total South African society cannot be analysed in terms of one class system, since the similar segment of African society does not "...enmesh associatively with the European middle class in South Africa". This implies, at least to my way of thinking, that the class concept could nevertheless be used within distinct racial sub-sections of the South African social structure. That is, one could identify upper, middle and lower classes for European, Indian, African and Coloured populations, and have four class systems instead of one. (Is this not precisely what the policy of separate development is intended to achieve?) Yet Brandel-Syrier also denies the applicability of the class concept to Africans in particular, though I find her reason for doing so rather obscure. She states (1971:xxix) that:

> "...to consider them in terms of 'European' class patterns... raises expectations about these Bantu individuals which they cannot possibly fulfil".

That is, she seems to attach some evaluative notion to the term "class", and rejects its use for that reason. Later on, however, she is willing to apply the term "upper class" to describe the position of African elites within their own racial (and local) community. These ambiguities are, perhaps, a further demonstration of the complexities surrounding the use of the term "class" -- especially in the South African context.

My own reason for rejecting the class concept in its totality for the present, pertains to the cultural distinctiveness of the elites, compared to the majority of the African population. It is my impression that elites are culturally distinct in both rural and urban areas, thus impeding the use of class analysis even in the urban context at present. Obviously, this situation can and must be expected to alter as economic development proceeds.

I have mentioned previously that education is the primary key to effective participation in a western-based economy. Occupational participation in turn yields financial rewards, which make possible the acquisition of certain material possessions, which symbolise the high status of those who own them. Thus conspicuous consumption becomes evident. Yet studies of occupational prestige undertaken in West, Central and South Africa, would appear to indicate that education is more important than wealth in the context of social status among Africans. The trader, for instance, may have an income well in excess of professionals such as teachers and ministers of religion, but he is consistently ranked lower on prestige scales. Indeed, in West Africa particularly, trading as an occupation is located within the traditional structure rather than the modern, and the traders' homes and attitudes are likewise traditionally-oriented (Lloyd, 1967 b). The ability of such wealthy traders to utilise the new cultural standard, is limited to copying patterns of consumption of the elites proper. While the acquisition of such material indices of financial success as electric stoves and refrigerators, may mark the trader as "progressive" within the traditional society, his social status remains lower than that of the relatively lowly clerk, who earns much less, but whose occupation is clearly located outside the traditional framework. Thus, although educated Africans may be considerably less wealthy than many traders, their education and "western" occupations entitle them to the elite status denied to most traders.

This cultural referent of elite status, and the (structural) occupational foundations on which it rests, allow us to circumvent some of the thorny problems associated with "urbanisation" and socio-cultural change. While the towns and cities are obviously where most elites will be found -- for occupational openings suited to their qualifications are clustered in urban areas -- there is no valid reason why modern elites should not arise

or exist in rural areas where western cultural institutions are in operation, such as schools and hospitals. Hence individuals may be found who have been born, raised and educated in rural areas, but who have, through education and professional training, become participants in a completely different culture from the one into which they were born -- a culture, moreover, which is normally associated very firmly with town life and urbanisation. And when such individuals move into town for the first time (if they ever do), they are readily accepted into the elite stratum by their urban counterparts. Thus Wilson and Mafeje (1963:30 and 139) remark:

> "...teachers and other educated men and women from the oountry are very readily absorbed into the ooscuse-me group, though they have lived only a short time in town..."
>
> "...'school people' are more readily absorbed in town than the uneducated, and professional men and women -- teachers, nurses, lawyers, doctors -- are accepted immediately into the ooscuse-me group".

Some Differences Between Independent African States and South Africa Insofar As These Affect the Structure of the Elite Stratum.

Probably the single most important distinction between independent African countries and the Republic of South Africa lies in the obvious differences in their respective political systems. In South Africa, the powers of government are vested in the hands of the minority White section of the total population, whereas in most other African states, political authority is now in the hands of Africans, including the elites. Members of the elite stratum in these countries occupy the highest administrative and political offices, whereas in South Africa, this process of Africanisation has not yet occurred, except to a very limited extent in the "Homelands". Thus in South Africa, the African elite does not include a governing, or power elite, and in this respect, the situation resembles that of the colonial era in what is

now independent Africa. We are seeing now, however, the emergence of what might be described as a circumscribed political elite in South Africa -- circumscribed in that the political authority held by leaders such as Paramount Chief Matanzima (Transkei) and Chief Buthelezi (Zululand), is restricted to a clearly defined section of the total population in an equally clearly defined segment of the territory. What influence the emergence of such educated and, therefore, elite, political leaders will have on the elite structure in South Africa, remains to be seen, for their positions and influence, or power, are confined within a neo-traditional system of chieftainship, rather than being based on the western model of democratic government, as is theoretically the case in the rest of Africa.

A second important difference between South Africa and West Africa particularly, concerns the respective educational qualifications and occupations of their elites. In the literature on West Africa, the assignment of groups of individuals to elite status has been done in accordance with the primary criterion of education, for this has determined both occupation and social position in the non-traditional urban communities. The system of western education, initially introduced into Africa by missionaries, has been responsible for the social changes which have produced the new elites. In the colonial past, because education led to a well-paid job, the elite stratum was synonymous with the educated sector of the population. Thus it was possible for writers such as Busia (1956:430) and Tardits (1956:495) to equate elite status with literacy (in the sense of a minimum of six years of schooling), provided that the literacy rate in the total population was ten per cent or less. This crude index of elite status was formulated in the early nineteen fifties, and is probably no longer applicable in West African countries. Certainly it is inapplicable in South Africa today, where the literacy rate is supposedly high.

Despite one of the highest literacy rates in Africa, however, there are few professionally qualified African men in South Africa. In a total African population of nearly 15 000 000[1], there are probably not more than 3 500[2] university graduates, male and female; of whom less than ten per cent are in the fields of law, medicine and university lecturing. From Appendix II, it may be seen that there were greater numbers of African women professionals (including nurses) than men, in 1960, and it seems probable that this gap has widened in the past decade, although the 1970 Census figures are, unfortunately, not yet available. Thus in South Africa there exists a female-dominated elite stratum, which has had certain social consequences (which will be examined later in this thesis) that appear to be a reversal of the situation common in West Africa, particularly in the nineteen fifties.

South Africa has, then, a relatively insignificant male elite, and indeed, South African circumstances appear to have favoured the rise of a female elite. In the past two decades, for instance, nursing is one field to which African women have been actively recruited. Such was the impetus given to the training of African nurses, that today there are some ten thousand fully qualified, registered nurses, and over six thousand auxiliary nurses[3] in the African population. Thus African nurses alone constitute an extremely significant proportion of the total elite stratum, and the registered nurses alone may outnumber those men who are recognised by the African community as elites, by as much as two to one. One result of this situation, which I shall describe in detail later, is that in South Africa one finds professionally qualified women complaining about the dearth of men who may be regarded as their status equals and, therefore, suitable marriage partners -- the

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[1] Preliminary 1970 Census figures.

[2] Calculated from figures derived from the annual Survey of Race Relations, compiled by M. Horrell: 1960 - 1970.

[3] Figures supplied by the South African Nursing Council: correct as at 31 December 1969.

reverse of the situation reported from West Africa in the nineteen-fifties[1]. The imbalance in favour of women, in the South African elite stratum, would appear to be unique in Africa.

A third major structural difference affecting the position of the elites, is that this distinct female elite, in South Africa, has been created from a less educated stratum of the population than would be the case in West Africa. Taking the nursing profession in particular, only 18,1% (41 of a total of 226) of African registered nurses working in the Durban area, who responded to my research questionnaire, had achieved matriculation standard in their schooling. Thus in South Africa, we see not only a dominant female elite, but the paradoxical situation of a female elite whose schooling is, in the majority of cases, lower than that of many non-professional, non-elite men. Of course, in this particular case, the deficiency in school education is more than compensated by the professional training received by these women.

These differences between the structures of the elite strata in South Africa and other African states are, at least in part, attributable to policy differences regarding education and occupation. Official policy and legal statutes can have, and have had, important effects on the structure of the elite stratum. Some effects of official policies may be seen, particularly in South Africa, in the history of the nursing profession among Africans, which history also shows some of the factors that have helped to confer elite status on the members of that profession.

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[1] Jahoda (1955:79, footnote 13) quotes Mr. Kwesi Lamptey as stating in the Gold Coast Legislative Assembly:

> "One of the causes of unhappy marriages is that the educational standards of the men and the women do not agree...It is the duty of the government to see that the education of women is accelerated so that social upheavals, or married life which is being wrecked as a result of this, may be corrected."

CHAPTER THREE

THE HISTORY OF THE NURSING PROFESSION IN SOUTH AFRICA, WITH SPECIAL REFERENCE TO AFRICANS

The formal training of Africans to undertake nursing duties, has been in progress in South Africa for over one hundred years. During the crisis following the Xhosa Cattle Killing in 1856, four domestic servants were seconded to the Native Hospital, Kingwilliamstown, and became the first Africans in South Africa to be gainfully employed as nurses, or nursing assistants (Searle, 1965:129); and one of these women was retained in a permanent position at the hospital when the crisis period was over. In 1863, a formal training scheme for African nurses was inaugurated at Grey Hospital, Kingwilliamstown. Despite this early start, however, very few African girls entered nursing for the next sixty years, largely because there were so few who had been educated to a level that hospital authorities considered high enough to enable them to adjust to the concepts of western medicine and nursing.

At this period in the mid-nineteenth century, when the idea of training African girls to perform nursing duties, was beginning to take root in South Africa, Florence Nightingale was battling, in Britain, to establish nursing as a vocation suitable for young women from respectable social backgrounds, and to place the training of nurses on a sound and recognised basis. By 1877, the concept of hospital certification, for nurses who had successfully completed a course of training, had been introduced in South Africa at the Carnarvon Hospital, Kimberley, for European nurses. The first hospital to introduce training leading to the award of a hospital certificate for African nurses, in 1902, was Lovedale Hospital, a mission institution in Victoria East (Searle,

1965:268).

By this time, however, the Cape Colony had become the first country in the world to introduce legal provision for the voluntary registration of suitably qualified nurses, on a register maintained by the Colonial Medical Council. Such registration provided a measure of standardisation and recognition for the diverse trainings received at different hospitals, since a nurse could become registered only if she passed the examination conducted by the Colonial Medical Council. In 1892, twenty-two European nurses were admitted to this register, but it was not until January 1908, sixteen years later, that the first African, Cecilia Makiwane, was admitted.

Ceoilia Makiwane was already a qualified teacher when she entered Lovedale Hospital in 1903, to begin nursing training. She appears to have started a trend (that of teachers re-training as nurses), which still continues today. After she had been awarded the hospital certificate in 1907, Cecilia Makiwane was sent to the nearby Butterworth Hospital (a European institution) for several months' further training, prior to sitting the Colonial Medical Council examination, in December 1907. She was admitted to the register on 8 January 1908. Cecilia Makiwane's achievement in becoming the first fully qualified and registered African nurse in what is today the Republic of South Africa, is currently being honoured in the construction of a statue of her, which will be erected, when complete, in the grounds of Lovedale Hospital (which is today under the control of the Cape Provincial Administration). But beyond her personal achievement, the significance of her registration was that:

> "The Colonial Medical Council had thus accepted the principle that the register was open to all races provided they could reach the desired standard in the examination after undergoing an approved course of training." (Searle, 1965:269)

The Role of the Missions.

African education was, until some thirty years ago, sponsored, financed and controlled almost exclusively by mission institutions. Even today, the majority of nursing students at the McCord Zulu Hospital, and at St. Mary's and Charles Johnson Memorial hospitals, are the products of mission-controlled secondary schools. Western education, of course, was regarded by the missionaries in Africa, as being extremely important in the process of converting pagans to Christianity.

The missions led the way not only in the field of education, however, for curing the African sick was also largely ignored by ordinary European doctors, since it brought few rewards. Consequently, those who practised medicine among Africans in the nineteenth century, were, almost exclusively, missionary doctors. However eccentric some missionaries may appear in retrospect, it must be remembered that most of them subscribed to the idea of educating Africans to serve their own people, and indeed put this policy into practice.

Not surprisingly, their insistence on training Africans brought difficulties for the missionaries. For example, in order to provide personnel to meet the needs of the public in the field of health, some missionaries advocated the introduction of lower-level training in medicine and nursing, for Africans, than that demanded for Europeans undertaking the same tasks. Interestingly, such proposals were rejected (by nurses, doctors and the Colonial Medical Council), largely because of the fear of fee-cutting. The European nurse, for instance, was not prepared to countenance the idea of an African, with less training, depriving her of private patients because the African could afford to charge less for her services. The same objection held

for the medical profession, which, at this time, controlled the nursing profession as well. What the medical profession would not tolerate for itself, it could not sanction in nursing, for fear of setting a precedent[1]. As a result of this situation, training courses, examinations and standards were maintained at identical levels for Europeans and Africans, despite the pressure of work this caused for those ministering to the African population. However, the maintenance of identical professional standards for Africans and Europeans, in nursing particularly, has been an important factor in the prestige attaching to this profession among Africans. But the maintenance of such high standards also resulted in a very gradual expansion in the numbers of Africans who became nurses: some fifteen years elapsed between the time that Cecilia Makiwane was registered as a qualified nurse and the time that the second African nurse passed the qualifying examination, in the nineteen-twenties.

For some fifteen years, then, Cecilia Makiwane was the sole representative -- in the vanguard, perhaps -- of the trained nurse elite. However, in terms of the first criterion of elite status (that is, there must be a plurality of individuals), discussed in chapter two, an elite cannot consist of a single individual! Thus it would be more accurate to regard Cecilia Makiwane as an innovating deviant in her time, rather than the original representative of today's nurse-elites. From the nineteen-twenties, however, one can trace the development of this elite plurality, as more individuals were drawn into the small but expanding group of trained, registered African nurses.

By the nineteen-thirties, government hospitals had begun to follow the lead of the mission institutions in training programmes for African nurses. Apparently, however, they were less successful with their students than were

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[1] Today, proposals to introduce training for medical aides, are opposed vehemently by African doctors and medical students, who regard such proposals as threats to their own position.

the mission hospitals.

> "Yet our girls were of the same blood as those who failed in other institutions, particularly in the government hospitals. Why did they make such excellent nurses, whereas Zulu girls proved undependable in other hospitals? I believe that the difference at McCord's came from balancing discipline with play, from treating the girls as responsible individuals deserving of trust, and from impressing upon them the ideals of their calling...
> Some other hospitals treated probationers as inferiors or incompetents who must constantly be watched, and who would even then prove unreliable. If they sensed from their superiors' attitude that only the worst was expected, what incentive was there to give of their best?" (McCord and Douglas, 1951:279)

The missionary policy of deliberate inculcation of international ethics, both of nursing and of Christianity, into African nurses, is evident from this quotation. The nurses were encouraged to think of themselves as qualitatively different from their uneducated kinsfolk and neighbours. The idea was impressed upon them that their task was to uplift and educate, as well as to nurse, the members of their own (racial) communities. The nurses' own identification was with the educated, the western -- not the primitive and traditional. First their mission schooling, and then their nursing training, removed them from their own cultural background(s) to a great extent, and aligned the nurses with the culture(s) of the West.

Partly because the nursing profession was opened to Africans slightly later than was teaching[1], and partly because of the practical nature of nursing skills, nursing was <u>initially</u> considered good enough only for those girls who were not regarded as sufficiently intelligent to teach[2]. By 1920,

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[1] Searle (1965:269) states that, in 1910, there were 3 446 "Bantu Primary School Teachers" in the Cape, and one registered nurse, Cecilia Makiwane.

[2] McCord (McCord and Douglas, 1951:186) says of one of the first group of student nurses (who started in 1910) at the Mission Nursing Home:

> "Her father, far from objecting, remarked grumpily (of his daughter's proposed choice of career) that his daughter was too stupid for anything else".

PLATE III.

(a) The Assistant Matron's morning ward round: the matron (second left) checks treatment records with the student nurse (extreme left) who is dispensing drugs.

(b) The McCord Hospital choir, composed of student nurses, leads the singing at the annual Nativity Play. The choirmaster is one of the hospital doctors.

however, the idea that nursing could be a reasonable career, was becoming established:

> "So many native girls were now eager to become nurses that we could select only the best..." (McCord and Douglas, 1951:232)

More and more Africans entered nursing, although the overall numbers, especially of registered nurses, remained small. In the nineteen-thirties, the expansion became more noticeable. The second World War underlined the usefulness of the nursing profession, and enhanced the status of nurses considerably. Immediately following the war, the critical shortage of both European and African nurses in South Africa, resulted in improved conditions of training and service in the government hospitals, and increased pay. All of these factors combined to improve the status of the nurse (in both European and African communities) and over time, a career in nursing came to be regarded by African girls as preferable to teaching (which, until very recently, was the only alternative).

The Quest for Professional Autonomy.

In the early years of the twentieth century, there arose among European nurses in South Africa, a movement designed to free the nursing profession from the statutory control of the medical profession, and for nurses to assume responsibility for nursing affairs. This movement was not unconnected with the women's rights movements of the years following the first World War. Ironically, the person who was primarily responsible for the formation, in South Africa, of an association intended to achieve such professional autonomy for nurses, was himself a man and a doctor! It was largely through the efforts of Dr. John Tremble that the South African Trained Nurses Association (S.A.T.N.A.) came into existence, in 1915. This body successfully sought affiliation with the International Council of Nurses (which was formed in the

closing years of the nineteenth century), in 1922.

Registration as a trained nurse was still voluntary at this time, but only registered nurses were admitted to the S.A.T.N.A. In the late nineteen-twenties, however, when African registered nurses, who were eager to participate in the affairs of their profession, sought admission, they were refused. Consequently, in 1932, these African nurses formed their own Bantu Nurses Association. Because there were so few qualified African nurses at this time, admission to this association was thrown open to nurses who had only a hospital certificate, as well as those nurses and midwives who were registered with the Colonial Medical Council. The formation of the Bantu Nurses Association was an early indication of the distinct identity of African nurses. It is tempting to speculate that this formal association, which was affiliated to the White South African Trained Nurses Association, was one of the factors which led to nursing becoming a more popular career choice than teaching, among African girls. Certainly such an association could have been regarded as status-enhancing, in a society where contact between black and white persons was restricted, and where Europeans were regarded as having the "higher civilisation".

Initially, the European nurses' agitation for their professional autonomy, had little success. The Medical, Dental and Pharmacy Act of 1928 made provision for two representatives of nursing interests (either doctors or registered nurses) to be elected to the Colonial Medical Council, and to have full voting rights only on matters affecting nurses. But dissatisfaction and agitation continued, culminating, in 1942, in an attempt to establish a trade union for nurses. Trade unionism in nursing was averted by the hasty passage, through the Legislative Assembly, of the Nursing Bill, which became law a mere fifteen months after its first reading.

Legislation Affecting the Nursing Profession.

(a) The 1944 Nursing Act.

In terms of this Act (number 45 of 1944), the control of nursing affairs passed from the Colonial Medical Council to two entirely separate, official organisations, the South African Nursing Council (S.A.N.C.) and the South African Nursing Association (S.A.N.A.), both of which were created de novo.

The South African Nursing Council assumed most of the functions concerning the nursing profession, which had previously been held by the Colonial Medical Council. It is concerned with the protection of public interests and the maintenance of professional standards in nursing practice. The S.A.N.C. may take legal disciplinary action against members of the nursing profession whom it finds guilty of malpractice. The S.A.N.C. also prescribes syllabi for the various training courses, and conducts examinations; approves and inspects training institutions and their facilities; and maintains registers for students as well as trained nurses. The 1944 Act provided for the compulsory registration with the South African Nursing Council, of all qualified, practising nurses, on a single register, regardless of racial or other considerations. And in terms of this Act, any nurse might be elected to serve on the Council, provided she was fully trained and registered.

The South African Nursing Association, which is concerned primarily with the interests of nurses themselves, has a function complementary to that of the South African Nursing Council. The South African Nursing Association is the only official organisation of nurses in South Africa, and compulsory membership of this organisation is legally enjoined on all practising nurses. Thus the creation of the S.A.N.A. entailed the incorporation of members of

the older South African Trained Nurses Association and the Bantu Nurses Association, as well as those nurses who had not bothered to join these associations. South Africa is the only country in the world where membership of a professional association designed to protect the interests of the nurses themselves, is legally enjoined on all practising individuals.

The South African Nursing Association is concerned with nurses' working conditions and salaries; with promoting further study in the field of nursing by awarding scholarships and bursaries for post-basic study; and with effecting communication between widely dispersed members of the nursing profession, by means of the monthly publication of the South African Nursing Journal (in which papers and official notices are published and vacant posts are advertised). In terms of the 1944 Act, the South African Nursing Association was to be served by a Board of elected representatives, whc might be of any race, creed or nationality, provided that they were trained and registered nurses.

The non-discriminatory provisions of the 1944 Nursing Act drew nurses of all races into much closer association than had formerly been the case. Not only did one professional association replace two, not only were all nurses registered on the same register, but this was actually legally compulsory. In theory -- although this never happened in practise -- an African nurse could have been elected to serve either on the South African Nursing Council, or on the Board of the South African Nursing Association. The pace of development of African nurses in particular, and the necessary co-operation and collaboration on an interracial basis, proved unacceptable to many White nurses.

> "When the Nursing Bill of 1943 was rushed through Parliament, sufficient attention had not been given to this question...

> of a non-White nurse in a quasi-judicial role in disciplinary or ethical matters...There were many nurses who believed that the hard-won professional status and statutory responsibility could be jeopardised by exposure to professional immaturity and inexperience and widely divergent cultural concepts." (Searle, 1965:234, 235)

The contrast between the attitude described in this quotation, and the attitude of the missionary organisations mentioned previously, is quite evident. While certain people, such as the missionaries, were striving to align African nurses (and other educated Africans) with the culture(s) of the West, the majority of South Africans were not prepared to concede that this was desirable, or even possible. Such persons were, in effect, not prepared to recognise the "proto-elite" status of their African colleagues, and it was only five years after the triumphant passage of the 1944 Nursing Act into the statute book, that the first rumblings of discontent, which pertained to the non-discriminatory nature of this legislation, were heard. In 1949 (the year following the advent of a Nationalist government), a move for the amendment of the Nursing Act was tabled in the Legislative Assembly, but was shelved in favour of more "urgent" legislation[1]. Two years later, in 1951, a referendum was conducted by and within the South African Nursing Association, on proposals to limit the membership of the S.A.N.C. and of the Board of the S.A.N.A., to Europeans only, in law[2]. The move for amendment culminated in the Nursing Act (Amended), number 69 of 1957. The provisions of this Act extended the policy of separate development, or apartheid, into the nursing profession, and went far beyond the proposals approved by the slender majority in the 1951 referendum.

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[1] Horrell, M. (compiler) Annual Survey of Race Relations, 1949-50:35.

[2] See Jarrett-Kerr (1960). Chapter four deals with this period of nursing history (which is virtually ignored by Searle, 1965), in some detail. In this referendum, of a potential total of 9 866 votes, only 2 526 were actually cast: 1 422 were in favour of and 1 104 were against these proposals.

(b) The 1957 Nursing Act (As Amended).

The result of this Act was to separate nurses on the basis of their racial classifications, in distinct contrast to the provisions of the 1944 Act, which, as has been shown above, drew all nurses together in their profession, regardless of differentiating characteristics such as race or nationality.

Within the framework of the South African Nursing Council, the 1957 Act provided for the maintenance of three separate registers for each nursing qualification (that is, general nursing, midwifery, mental nursing, etc.), for European; Coloured and Indian; and African nurses. The single register that had been in operation since 1892, was thus fragmented by the 1957 Act. Furthermore, this Act gave the South African Nursing Council the authority to prescribe different syllabi for the different racial groups, at its discretion (which provision, up to the present time, has not been used). Finally, the S.A.N.C. was made responsible for an additional type of nursing training, the Auxiliary training, which (as mentioned previously) is of shorter duration than the general training and is geared to provide nursing personnel to undertake routine, practical nursing tasks. In line with the 1951 proposals put to members of the South African Nursing Association, the potential composition of the South African Nursing Council was altered in law, membership of the Council being restricted to Europeans only. Representation of the interests of non-European nurses was catered for by the introduction of two Advisory Boards, one for Africans, and one for Coloureds and Indians, with which the single European representative of each non-European group (on the Council), was expected to liaise.

The effects of the 1957 Act on the South African Nursing Association,

were similar. Membership of the Board of the Association was restricted to European nurses, and Advisory Committees were created to tend the interests of the other two groups. These Advisory Committees, again, liaised with their European representatives on the Board. Thus direct representation of non-European interests on the South African Nursing Council or on the Board of the South African Nursing Association, became a legal impossibility. Moreover, professional gatherings and meetings of nurses under the auspices of the South African Nursing Association, became racially differentiated as well. Even the biennial congresses of the S.A.N.A. were triplicated, thus restricting professional as well as social interaction between nurses of different races. Formal communication between nurses who belong to different racial categories, is thus effected only through the executive members of the Board of the South African Nursing Association, since they alone deal with all three groups.

However, despite the diminution of both professional and social contact between nurses having differing racial identities, as a result of the 1957 Act, the previous thirteen years of close formal association, and the still-existing links of all nurses to the (differentiated) framework of the South African Nursing Association, nevertheless involve a far closer rapprochement of Africans and Europeans in the nursing profession than in other professions, such as teaching, in South Africa. (The medical profession is, perhaps, still an exceptional case.)

The structural changes in the formal organisations serving the nursing profession, which were a result of the 1957 Act, were considered by many nurses to be contrary to the ethics of nursing. Discrimination on the basis of race, nationality, colour or creed, is explicitly rejected in the various nursing pledges taken on entry to full membership of the profession. Such discrimination is sufficient cause for membership of the International Council

of Nurses[1] to be refused or terminated, and some South African nurses sought the expulsion of the South African Nursing Association from the International Council of Nurses, on the grounds of the discriminatory character of the 1957 Act. The Federation of South African Nurses and Midwives (F.O.S.A.N.A.M.) was established late in 1957, and sought affiliation with the International Council of Nurses, challenging the South African Nursing Association's right to membership on the grounds that it was condoning racial discrimination within the nursing profession, in South Africa. Although this challenge resulted in the South African Nursing Association receiving a severe reprimand (concerning the 1957 Act) and a warning about its future in the International Council of Nurses, its membership was not withdrawn. One may speculate, firstly, that had the international political climate of today (1971) prevailed in 1958, the South African Nursing Association would indeed have forfeited its membership as a result of the 1957 Act; and secondly, that the warning regarding South Africa's future within the International Council of Nurses, may help to explain the fact that an important provision of the Act -- notably differential training on a racial basis -- has never been utilised.

The Expansion of the Nursing Profession among Africans: Some Causes and Consequences of this Expansion.

I have already dealt with the gradual expansion of the nursing profession

[1] Membership of the International Council of Nurses is on an association, not individual basis, and only one association per country may be accepted for membership. Such membership is significant in that it confers international recognition of nursing standards in member countries. The International Council of Nurses is also the organisation through which qualifications may be recognised in countries other than those in which the qualifications were obtained. The benefits of membership are, therefore, considerable, and are appreciated fully by European nurses in South Africa, since there is considerable movement among nurses, from South Africa to other countries, and vice versa.

among Africans during the first half of this century. In the past two decades, however, the number of African registered nurses has increased phenomenally. In the last ten years alone, the numbers have nearly doubled, from approximately 4 600 in 1959 to nearly 11 000 at the end of 1969: of this latter figure, 9 112 were registered general nurses[1]. According to Searle (1965:276), this increase is a direct result of Nationalist government policy: African nurses are being trained to serve their own race group.

Although European registered nurses outnumber their African colleagues by more than two to one at present, it is interesting to note that there were nearly equal numbers of European and African students registered with the South African Nursing Council at the end of 1969. The increasing convergence in student numbers for these two groups, is shown clearly in table 2[2] and graph A (see page 52).

TABLE 2. Student registrations, European and African, with the South African Nursing Council, as at 31 December each year: 1960-9.

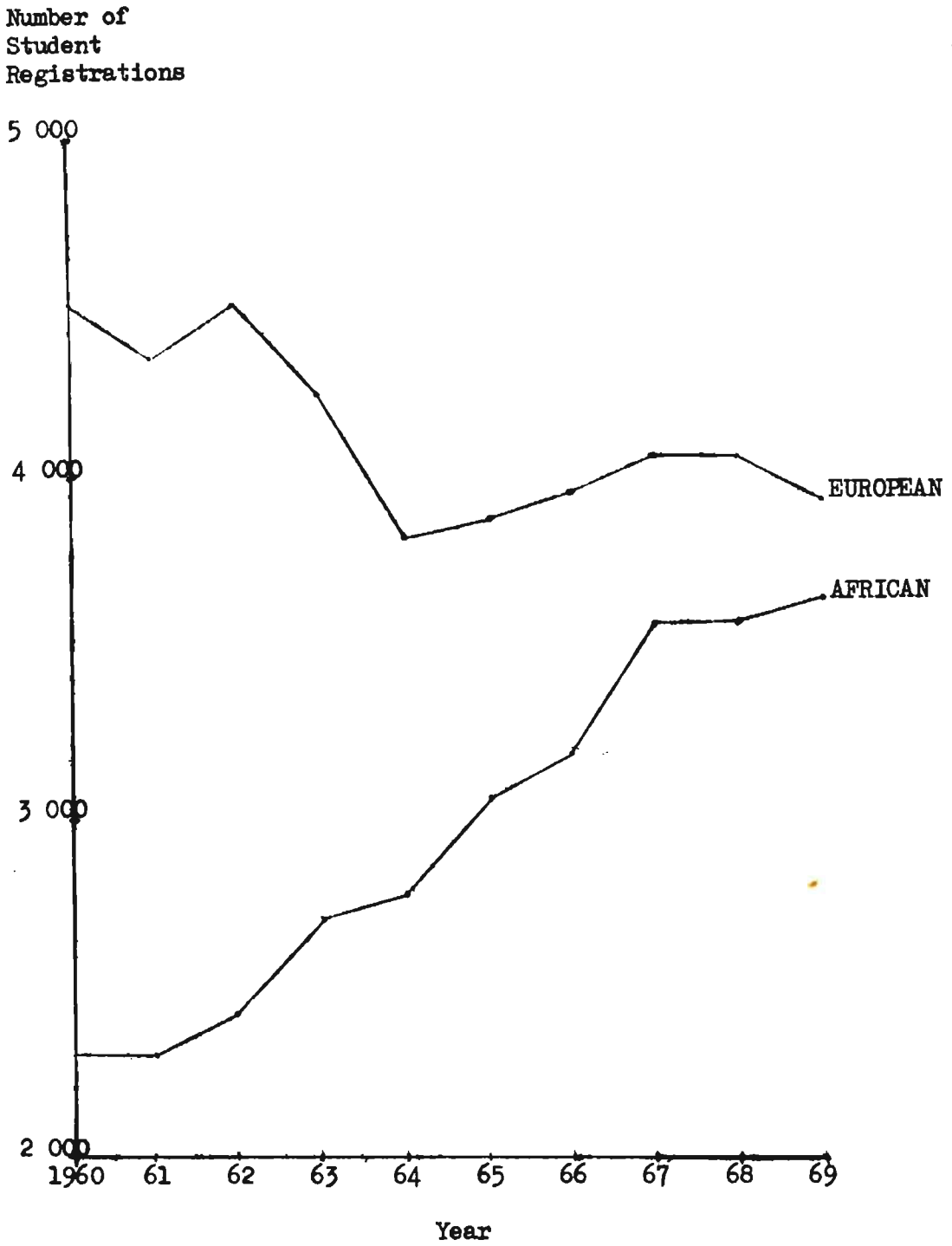
Year	European General Students	African General Students
1960	4 514	2 312
1961	4 344	2 309
1962	4 515	2 426
1963	4 243	2 700
1964	3 824	2 777
1965	3 870	3 045
1966	3 959	3 180
1967	4 061	3 567
1968	4 054	3 567
1969	3 938	3 635

These figures show clearly the extent to which the nursing profession

[1] There are other basic registrations, such as mental nursing, which make up the total: these figures have been supplied by the S.A.N.C.

[2] These figures have been extracted from the Report of the Fifth Council, S.A.N.C 1970, Annexure W, and pertain only to general nursing students.

GRAPH A.



NUMBERS OF STUDENT REGISTRATIONS, EUROPEAN AND AFRICAN, WITH THE SOUTH AFRICAN NURSING COUNCIL, AS AT 31 DECEMBER EACH YEAR.

(See Table 2.)

has opened up among the African sector of the population, particularly in the last ten years. The interesting question arises as to what effect this expansion has had on the position of the African nurse in her own racial community. Most of my informants who had trained in the late nineteen-fifties, mentioned the prestige associated with nursing, among Africans, at that time: many cited it as a factor influencing their own choice of career. Equally, most of this generation are adamant that the prestige associated with nursing has fallen since that time, and there are a number of indications as to why this might be so. I have no objective, scientifically-tested proof that the prestige of nursing has in fact declined among Africans.

The first factor that one should consider, is that the prestige arising from scarcity falls as more people enter a given occupation. Thus it would appear to be possible that, as the number of African nurses has increased, so the public esteem for their achievement has fallen. This in turn might be associated with a slackening of control over individual behaviour as the number of nurses has increased, with a corresponding decrease in feelings of solidarity among colleagues.

More important than this possible dilution of an elite group as it expands, however, are the factors associated with the 1957 Nursing Act (As Amended). Not only did this Act effectively sever the prestige-conferring contact African nurses had enjoyed with their White colleagues, it also conferred recognition upon a lesser type of nurse, the Auxiliary or Enrolled nurse. Where the lay public is not in a position to appreciate the differences between these two categories of nurse, the auxiliary draws prestige from the registered nurse, who, in turn, may be identified with the auxiliary. Because of her different and, in certain respects, qualitatively inferior, training, the auxiliary nurse (who has not undergone as intensive a socialisation

process as the registered nurse), is not subject to the same internalised control over her actions and behaviour. Nor, interestingly, is she subject to the same external control, since she is merely an "associate member" of the nursing profession. While there are few auxiliary nurses among White South Africans, there are over six thousand auxiliaries in the African population. Thus the official recognition of the auxiliary nurse has affected the status and prestige of the African registered nurse to a far greater extent than it has affected that of her European counterpart.

However, while these factors are quite apparent in explaining why it is possible that the prestige attaching to a nursing career may have declined among Africans, in the past decade, in the absence of conclusive evidence that it actually has declined, one must also consider the possibility that this postulated decline is merely a subjective opinion of older nurses. It may be part of the generalised feelings of superiority (or perhaps a reflection of feelings of inadequacy and consequent assertion of status?) of the older generation. The fact that the majority of my informants who believed that nursing had lost prestige in the eyes of the African population, were in the early- to middle-thirties age category, does not afford great support to this latter possibility.

Possibly the most credible explanation for this postulated loss of prestige, is that it is simply a reflection of a loss of prestige in the eyes of African nurses themselves: in other words, that nursing has lost some of its attraction as far as the nurses themselves are concerned, perhaps as a result of the 1957 Act. This explanation would appear to be logical, since it is obvious, from the figures in table 2, that the nursing profession has been attracting new recruits with ease in the past ten years. Presumably, if recruitment is easy, an occupation cannot have suffered too great a loss of prestige in the community at large.

A second major consequence of the deliberate expansion (in terms of government policy) of the nursing profession among Africans, is seen in the narrowing of the discrepancy between numbers of European and of African nurses, and particularly student general nurses. The trend towards converging numbers for these two racial categories, may well have caused unease in certain circles among European nurses: it is difficult to see how the present structure of Advisory Boards and Committees to cater for non-European nursing interests, can be maintained, let alone justified, should European nurses become a minority group in the profession as a whole. Given the rate of expansion of the nursing profession among Africans in the past ten years, and the figures for student registrations shown in table 2, it is not difficult to see that this trend could constitute a threat to the position held by European nurses at present. Certainly it seems somewhat paradoxical that the entrance requirements for general nursing students, were recently raised from the Junior Certificate to the standard ten level, when there exists an acknowledged shortage of nurses in South Africa[1].

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[1] In view of the ratio of 1:152, of European registered nurses to total European population (Report on Nursing Service in the Republic of South Africa and the Territory, 1970:5, table 2), it may sound contradictory to say that there is a particular shortage of European nurses. The shortage of European nurses, relative to the number of posts open to them, is, however, a result of the situation where many European nurses do not use their qualifications. The overall shortage of nurses has become so acute in Natal, that all nurses working in Natal Provincial Administration hospitals, will in future be paid overtime rates for work in excess of forty-four hours per week (see Daily News, Thursday, 12 August 1971). At present, registered nurses work a forty-hour week. Moreover, according to press reports, the possibility of using African auxiliary nurses in European hospitals, to relieve the shortage, is under serious consideration, especially by private hospitals. One of the effects of the revised regulations governing admission to training, will be a rapid increase in the numbers of African auxiliary nurses, of course, as well as a decline in the rate of increase in the numbers of African registered nurses.

Furthermore, O'Reagain (1970) has outlined proposals for the extension of hospital services by the Natal Provincial Administration. Ten new hospitals, with a combined total of some ten thousand beds, are planned to serve the African population of Natal. And O'Reagain (1970:176) states that:

> "It is intended that any deficiency in the number of nurses will be made good before all the hospitals are opened."

Recent Changes in Nursing Policy, and Some Probable Effects of these Changes, with Specific Reference to the African Population.

In November 1970, new regulations[1] governing the admission of prospective student nurses to the general training course, came into effect. In terms of these regulations, a prospective general nursing student must have a minimum educational qualification of the standard ten certificate, or else she must already be an enrolled auxiliary nurse. Previously, the Junior Certificate (standard eight level) was the minimum requirement.

In the final matriculation examinations at the end of 1968, less than two thousand Africans in the Republic of South Africa (including the Transkei) and South West Africa, obtained standard ten passes, and of this number, only three hundred and forty-two (342) were girls[2]. Thus it may safely be assumed that there will be a dearth of African applicants who may be accepted for the general nursing training, at least in the short- and medium-term future. This is particularly so in view of the fact that the small numbers of African girl matriculants have a fairly wide range of potential occupations from which to choose a career, and a course of university studies is usually of top priority for Africans in this position.

While it must be assumed that the new regulations governing admission to nursing training, have been brought into existence in an attempt to raise standards within the nursing profession, certain adverse effects may, perhaps, be anticipated, in view of the educational attainments of Africans at present.

"Table 2.4, in the section dealing with the educational level of students, shows how small the number of Bantu school

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[1] Proclaimed in the Government Gazette, 28 November 1969: no. 3792.

[2] Report on Nursing Education in the Republic and South West Africa, 1970:11, table 2.4,

> leavers is who attained the standard 10 certificate, with matriculation exemption (twelve school years) at the end of 1969. The number of these matriculants recruited for nursing training is not known."[1] (Emphasis supplied.)

In the light of this statement, there would appear to be two possible explanations for these new regulations. They may be the result of ignorance:

> "...based on a prideful -- and, in my view, unjustified -- estimate of the state of our country's medical and nursing services. We are not yet a fully developed country, for nursing services are notably uneven between city and country, and in fact, for the rural Black population, are sparse to the point of inadequacy."[2]

The second possibility is that this move to raise the entrance qualifications is a deliberate, if indirect, discriminatory move on the part of some European nurses, who feel that their position is somehow jeopardised by the increasing numbers of their African equals in the professional sphere. It may be assumed that these nurses have been supported, in all good faith, by others who are genuinely concerned with the raising of professional standards, particularly among European nurses, and with increasing the occupational prestige of nursing among Europeans in order to attract recruits of high calibre.

In the context of the South African situation as a whole, and of the 1957 Nursing Act (Amended) in particular, it is hardly surprising to find that African nurses themselves interpret the new regulations as a discriminatory move. It should be noted, however, that African registered nurses do admit that standards should be raised, particularly since few African trainees holding the Junior Certificate, have a good grasp of the English language,

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[1] Report on Nursing Education in the Republic and South West Africa, 1970:4 & 11, table 2.4. Incidentally, this table purports to give figures for the final examinations of 1968, not 1969.

[2] Personal communication from Dr. E. A. Barker: 14 September 1970.

which they are required to use during their training -- a failing usually attributed by African nurses to Bantu Education. The policy of raising standards is not questioned, but the apparent mis-timing of the introduction of the revised entrance requirements, is deplored, particularly by African nurses.

Certainly the likely effects of the introduction of these new regulations reverse, in some respects, previous policy in the nursing profession. For instance, where previously it was regarded as undesirable for a single hospital to run both general and auxiliary training courses, this situation has now become normal rather than exceptional. Non-European hospitals in particular, have been forced to establish the auxiliary course in order to ensure that the hospitals have adequate numbers of nursing staff, as well as to provide the possibility of producing some suitably-qualified applicants to undertake the higher level training in the future. Some hospital authorities, particularly of mission institutions, regard the continuation of the general nursing course as a matter of principle[1]. The smaller, rural mission hospitals have been affected most drastically by these new regulations, of course, and some of them face the possibility of having to abandon the general training. It is possible that some mission institutions see these regulations as an indirect attempt to restrict what influence they may have, particularly in the promotion of a non-racial society within South Africa. The large-scale bureaucracies of government and provincial hospitals operate within the framework of official policy: private mission hospitals have, in the past, been outside this field of control. How this situation will alter, following the assumption of financial responsibility for the majority of previously autonomous mission

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[1] This attitude is exemplified in the following extract from a personal communication from the medical superintendent of Victoria Hospital, Lovedale (formerly Lovedale Hospital):

> "We have been training African nurses for the same certificate as that awarded to European nurses since 1903 and it is our intention to continue to do so." (15 September 1970)

hospitals, by the Department of Bantu Administration, remains to be seen.

The single most obvious, and possibly most important consequence of these new regulations, will be a decrease in the growth of the number of African registered nurses, who are "full members" of the nursing profession, and who hold full voting rights in the South African Nursing Association. Correspondingly, there will be an increase in the number of African auxiliary nurses, who are "associate members" of the nursing profession, with no voting rights within the South African Nursing Association, at present. A proposal[1] to give auxiliary nurses voting rights, which was tabled at the 1970 Congress, was withdrawn at the request of the Board of the South African Nursing Association: this enforced withdrawal may, perhaps, be significant in the present context. Is the restriction on Africans attaining registration, and the expansion of the auxiliary category among Africans as a result of the revised entrance requirements, the means by which African nurses may be contained within the framework of the South African Nursing Association (thus ensuring continued South African membership of the International Council of Nurses) and yet not constitute a threat to the position of the European nurse -- at least in the foreseeable future? This is, of course, further speculation on my part, yet this interpretation does not contradict the available facts.

Paradoxically, however, despite the foreseeable negative effects of the revised entrance requirements for the general nursing course, on some non-European hospitals as well as African registered nurses, one effect of these regulations may be to raise further the status of the African registered nurse. As a result of these regulations, the nursing profession is being closed once more, at the higher level of qualification, in contrast to the expansion

[1] S.A.N.A. Resolutions for Discussion at the Biennial Congress for Bantu Members: B.C.B. 8 - 6/70; page 4, no. 13.

that has occurred during the past two decades. Thus the achievement of registration may be expected to become relatively less frequent among Africans, since the raised entrance requirement may make the general nursing course, leading to registration, almost as difficult to enter as the newer professions (such as physiotherapy and radiography) and the universities. This situation can only raise the social standing of the African registered nurse, especially among the African population. The process of closure may be expected to reinforce and even intensify the elite nature of the nursing profession among Africans. The social influence and leadership potential of the African registered nurse may thus be expected to increase as well. Developments in the nursing profession in the past decade do not contradict Jarrett-Kerr's earlier (1960:121) opinion that "...few people are more important on the seething continent of Africa than the African nurse".

In this chapter, I have tried to show the gradual processes, in South Africa, whereby African nurses have attained such importance. In the following chapters, I intend to examine some aspects of the nurses' elite status (resulting from their professional identity), and the effects that this status has on their social, kin and marital relationships.

CHAPTER FOUR

ELITE DIFFERENTIATION: NURSES AND NON-NURSES

There is one common view which holds that, in most societies, women especially are the conservers of tradition and the opponents of change. A contrary opinion has, however, been put forward by Brandel (1962:220), who suggests that, in situations of contact with Western cultural ideas, women in small-scale societies can sometimes gain more from modernisation than can their menfolk. For women, modernisation can lead to leadership opportunities, for instance, whereas for men, it often means restriction, even loss, of their traditional domestic rights. This suggestion may well explain why, in certain countries, African women have been reported to be more anti-traditional in attitude, than the men (Omari, 1960:208). And as could be expected, the rejection of traditional values and behaviour appears to be most marked among educated women.

The idea that women may benefit from modernisation, possibly at the expense of men, has been pursued by Banton (1967:186), who suggests that, in countries where Whites control racial hierarchies, the subordination of non-White men permits non-White women to seize greater domestic authority, and may thus give rise to the phenomenon of "matrifocality". It would also appear that women of subordinate races are regarded as constituting less of a threat to the position of the dominant race, than are the men. One should, then, see the expansion of the nursing profession among Africans in South Africa, in the light of the fact that African nurses are mostly women[1]. For whereas professional opportunities for African men in South Africa have been relatively restricted, Searle (1965:276) asserts that:

[1] There were 93 African male registered nurses in South Africa at the end of 1969: figures supplied by the S.A.N.C.

> "No single factor contributed more to the rapid development of the non-White nursing services than the policy of separate development."

Perhaps the government policy of training and employing increasing numbers of African women teachers, reported by Kuper (1965:172-3), affords further support for Banton's point.

While it is possible that a "White supremacist" situation may work to the relative advantage of women belonging to subordinate, non-White racial strata, the commitment of educated African women themselves to modernisation, is most important in the development of elite values. In addition to these two factors, however, there are elements in the structure of the nursing profession itself, which contribute to the overall elite status of African nurses in South Africa. I shall discuss some of these structural features of the nursing profession in relation to certain of the defining characteristics of elites, outlined initially in chapter two.

Firstly, the nursing profession is closed, and this closure has resulted in nurses forming a clearly identifiable collectivity. Admission to this closed profession is regulated in three ways: a minimum educational standard is demanded before a prospective nurse may be accepted for training; a protracted period of time must be spent in acquiring the skills specific to this occupation and, at the end of this period, competence must be demonstrated in both practical and written examinations; and, finally, the person who has fulfilled these two preliminary requirements, must be registered with the official professional body (the South African Nursing Council), before she may practise as a nurse without fear of legal prosecution. However, even though there are these three distinct restrictions on admission to the closed professional group, it must be noted that anyone may try to attain these requirements: the professional identity is achieved, not ascribed.

In addition to the formal closure of the nursing profession by its controlling authority, however, the removal of student nurses from the wider society (they live in a nurses' residence while training, and associate with few people outside the hospital "world"), leads to an awareness of their own separation from ordinary society. With this awareness comes identification with others in the same situation. Nurses, whatever their race, nationality or religious affiliation, are very much aware of their identity as nurses. In part, this identification stems from the system of ethics inculcated into nurses during their training, for the ethical code lays down certain behavioural expectations to which nurses are expected to conform. The various nursing pledges, recited at graduation ceremonies, embody these expectations.

> "I solemnly pledge myself to the service of humanity and will endeavour to practise my profession with conscience and with dignity.
> I will maintain by all the means in my power the honour and noble traditions of my profession.
> The total health of my patients will be my first consideration.
> I will hold in confidence all personal matters coming to my knowledge.
> I will not permit considerations of religion, nationality, race or social standing to intervene between my duty and my patient.
> I will maintain the utmost respect for human life.
> I make these promises solemnly, freely, and upon my honour."[1]

Insofar, then, as the ten thousand-odd African registered nurses in South Africa, are part of a collectivity closed by professional requirements, and are aware of themselves as a distinct occupational group, they may be regarded, in a preliminary way, as part of the African elite. In a previous chapter, I have discussed the development of the nursing profession among Africans: it is now necessary to see nursing in relation to other occupations open to Africans in South Africa.

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[1] The International Council of Nurses Pledge, reproduced here, is probably the most widely-used nursing pledge in the world.

Occupational Opportunities for African Women in South Africa.

Career opportunities for African women are limited, but expanding. Today the potential career choice open to African women includes teaching, nursing, physiotherapy, radiography, social work, general secretarial duties, even graduate research work and university lecturing. All of these occupations, each of which requires a recognised and lengthy training, obviously carry greater financial remuneration, prestige and job security than do domestic service, menial office jobs, or factory work, which are the alternatives to a professional training and career. In the past, however, the career choice was limited to nursing and teaching. While teaching was the first professional occupation opened to African women, nursing gradually became the more popular career choice, as a result of higher salaries, the predominant identification of nurses with an urban way of life, and the increasing numbers of nurses.

There are some obvious material advantages attached to the nursing profession, as opposed to teaching, for African women. During her three-year training, the student nurse is paid, housed, fed and supplied with free uniforms and shoes. The trainee teacher, on the other hand, pays for her tuition and all of her clothing, and although she may be housed and fed in a boarding hostel, the conditions under which she lives are likely to be less favourable than those of a nurses' home. Furthermore, job security is greater in nursing than in teaching, especially for the married woman, since the married teacher is declared redundant as from the date of her marriage. Even maternity leave is allowed for the nurse: the Natal Provincial Administration, for instance, allows registered nurses two periods of six months each for (unpaid) maternity leave, while holding the nurse's post open for her return[1]. In terms of working conditions, the nursing profession is more attractive

[1] The nurse can also claim unemployment insurance during maternity leave.

than teaching, even though the actual work may be regarded as being mentally less demanding and physically more taxing.

Moreover, the trained nurse will not usually be posted to "raw" country areas, as the teacher often is. And in terms of career potential, the registered nurse holds a qualification that is recognised internationally. Below the graduate level, African teaching qualifications in South Africa do not carry the same international recognition. In addition to the identification of African nurses with nurses in other countries, there is also the factor of relatively close association with European nurses (and doctors) in South Africa, whereas teachers of different races are not linked in a common professional association. Finally, and perhaps crucially, there is a good deal of prestige attached to hospitals and hospital work, by the lay African population, and thus, for African girls, "...nursing is probably the most popular professional career" (Preston-Whyte, 1969:24-5)[1].

Given the advantages of nursing over teaching, it is not surprising to find rivalry between African nurses and teachers, for nurses regard themselves as being socially superior to teachers, who resent this attitude. Each professional group holds certain stereotypes of the other, usually derogatory. Nurses regard teachers as being conservative, not sharing the same western-based value system to the same degree as do the nurses themselves. At the same time, they pity those teachers who have to teach and live in rural areas, divorced from the company of other educated people in the general community. Teachers, on the other hand, regard nursing as "dirty work", and see nurses as being unwarrantedly snobbish in view of the work they do. Nursing is regarded as mentally less demanding than teaching, and nurses themselves are

[1] In passing, it should be noted that the prestige attaching to nursing would appear to be much higher among Africans than among Europeans in South Africa, and this differing prestige rating is quite obviously related to their differential career opportunities.

stereotyped as being concerned only with their appearance.

Despite this occupational rivalry between nurses and teachers, however, a teacher may be instrumental in helping a schoolgirl to decide on nursing as a career. Especially where hospitals draw significant numbers of their students from particular schools[1], teachers may play an important part in advising suitable students of the merits of a nursing career. One suspects that European teachers have, perhaps, been more important than Africans in this respect, but nevertheless, African teachers are well aware of the objective advantages of nursing. Indeed, nearly ten per cent (22 of 226) of the registered nurses who responded to my research questionnaire, had themselves qualified as teachers prior to entering the nursing profession. (I am not aware of any similar but reverse trend -- of registered nurses re-training as teachers.)

The relationship between African nurses and African teachers may be interpreted in the light of their competing interests within the elite stratum: nurses and teachers may, in some respects, be regarded as rival elites. Tensions in the relationship arise from jockeying for prestige, and it seems that South African circumstances have favoured the nurses at the expense of the teachers, at least in the present. But although internal divisions along occupational lines do exist within the elite stratum, such relatively minor differences are ignored by nurses when they consider the structure of African society as a whole. Within the African population, the most important distinction, particularly in social terms, is found between the educated and the uneducated. "Educated" and "uneducated" are basic social categories in modern African society.

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[1] The McCord Zulu Hospital, for instance, draws approximately one-third of its students from Inanda Seminary, as a result of the historical link of both of these institutions to the American Board of Missions.

Bases for Social Categorisation among African Nurses.

(a) Friendship.

In general, African nurses identify with others who are educated, regardless of occupation: as one nurse[1] put it, "...we do not associate ourselves with the people". However, within the elite stratum, nurses stress their identity as nurses, and this emphasis on their identity as nurses (rather than as educated people), is reflected in the friendships they form. These friendships are usually restricted, both numerically and within the professional category, and often cross-cut ties based on tribal identity.

The patterns of friendship among elites are important. As Jacobson (1968:125) states, with specific reference to Mbale (Uganda):

> "...friendship with other elite Africans is critical in differentiating elite from non-elite...Friendship defines a major boundary, in ideology and practice, of the elite social system."

The factor of geographical mobility, of course, has an obvious and important bearing on the formation of friendships. When an individual has moved away from family connections, and kinsfolk are simply not there to draw the individual into the kin network, non-related friends must provide the framework within which much social interaction occurs. And while it is a truism that friends are selected, whereas kinsfolk are "ascribed", the strength and importance of friendship ties do reflect the cleavage, in contemporary African society, between elite and non-elite. African nurses are linked to non-elites by (among others) ties of kinship, but they seek and find satisfying social interaction with friends of elite status comparable to their own.

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[1] A delegate to the 1970 Congress.

Perhaps one of the reasons why friendships are so important to African elites, lies in the fact that the obligations of friendship are usually less onerous than those of kinship. African nurses, for instance, call upon friends to assist them in everyday difficulties. This assistance may range from borrowing baking pans to combing out tightly-plaited hair; or from buying a few items at market to advancing a short-term financial loan, but such aid does not involve any financial outlay that is not expected back in the short-term future. Kinship obligations, on the other hand, usually do involve non-returnable (and sometimes non-reciprocal) financial outlay, particularly when educational responsibilities are involved. However, the single most important obligation of friendship, as far as African nurses are concerned, is the holding in confidence of a friend's private and personal affairs, the ability not to "blab" to others[1].

African nurses do not form many friendships, but those that they do form are almost exclusively with other nurses. In fact, from informants' statements, it appeared that persons who were regarded as the closest friends of all, were often working at different hospitals, sometimes resident in different towns, who saw each other perhaps once or twice a year. Very often such close friendships existed between nurses who had been students in the same training group, and who had long since gone their separate ways, while the friendship itself had been continued over the years by correspondence and occasional holiday visiting. Perhaps one reason for the somewhat paradoxical closeness and durability of such friendships, lies precisely in the fact that the two individuals involved are <u>not</u> interacting in face-to-face relations, except on infrequent and irregular occasions. Both persons have, therefore,

[1] Vilakazi (1965:139) notes the stress on "privatism" found among those he terms elites (including nurses), in the rural Nyuswa area. "Shouting" (that is, making one's affairs public) is looked down upon by Christians, who regard it as typical pagan (and, therefore, uneducated) behaviour.

far greater control over this type of relationship, than either has in her relations with colleagues and others, with whom she is constantly interacting. The possibility of conflict arising and splitting the relationship, is thus reduced to a minimum in the situation where friends are separated geographically. In this context, it is significant that visiting, on a purely social basis, is restricted among African nurses, except between those who are very close friends: privacy is highly valued.

Thus friendships among African nurses not only differentiate elites from non-elites: they also stress the identity of nurses within the elite stratum. Nurses may be acquainted with teachers, may even interact with them on a fairly regular basis, but they do not regard teachers as friends. Nor, necessarily, do they regard all colleagues as friends, although friendship normally tends to be restricted to co-members of the nursing profession, and thus emphasises the occupational (and social) boundary separating nurses from non-nurses.

(b) Life Style.

If friendship is one index of the differentiation of elites from non-elites (and, therefore, a basis for social categorisation), life style is another such index. Life style is, of course, closely related to income, and educational, occupational and financial differences between elites and non-elites are reflected in their different standards of living.

The material rewards accruing from the African nurse's professional occupation, are considerably less than those accruing to her equally-qualified European counterpart, but are nevertheless sufficient to allow her to live in a style markedly different from that of the ordinary labourer, or unskilled

African worker. The material trappings of the nurse's social status are the prime focus for imitation by others, and it is partly these material possessions which give rise to the deference and respect which the African nurse is accorded.

Members of African society who live in a manner that can only be designated as "western" or "modern", provide the image of progress to other Africans in South Africa. Nurses, among others, provide such an image. Their homes, whether these are privately constructed or merely "improved" township houses[1], all reflect the relative financial well-being of the nurses and their families. The walls are plastered and painted; the kitchen is tiled; the floors may be parquet- or marley-tiled, or even carpeted; all rooms have doors, or some other means of ensuring privacy; where cables permit, electricity will have been installed. In these homes, the furniture is expensive -- lounge, dining room and bedroom suites, carpets and rugs, refrigerators, stoves, electric kettles and irons, bedside lamps, display cabinets, and so on. Virtually all such furniture, it must be noted, is acquired through hire purchase accounts, and it is highly doubtful whether nurses and their families (and other African elites in South Africa) would be able to maintain their present standard of living, were they not able to utilise this type of credit facility. The apparent ease with which nurses use hire purchase facilities may well, in itself, be a specific indication of their elite status, recognised in this way by the (European) firms with which they deal. Of course, not only nurses live in the manner described above. But the difference between the homes of nurses and those of other (aspirant) elites, is that the nurses <u>live</u> in their homes. Their homes do not have

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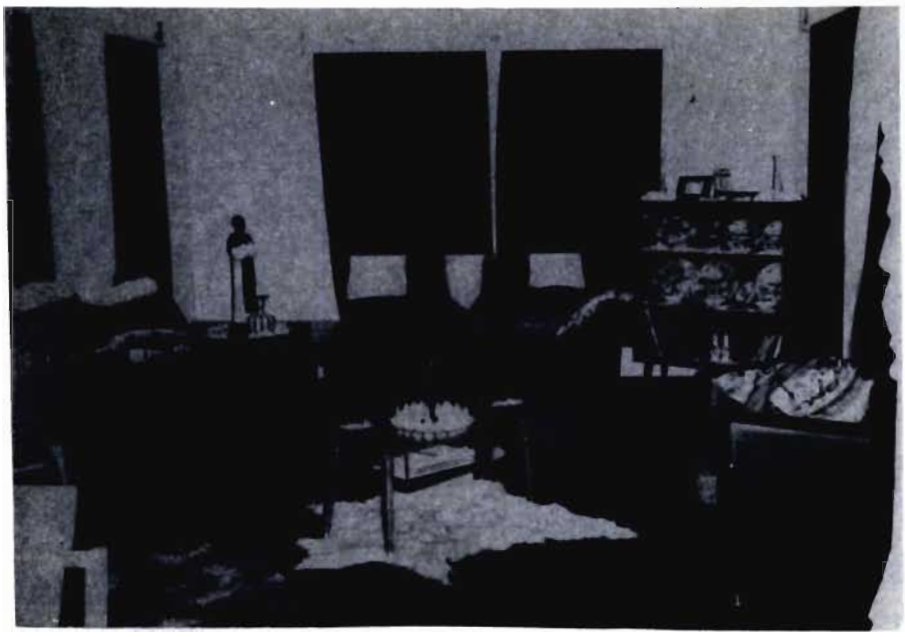
[1] Township houses, having either two or four rooms, are constructed <u>en masse</u> and sub-economically by municipal or government housing authorities. Usually the open brick is not plastered; the floors are merely concrete slab; there are no internal doors -- the house is merely a shell, for shelter. Any and all improvements must be financed by the tenants or purchasers, who are re-imbursed for improvements when the house is resold. (It must be resold to the township authorities in the initial instance.)

PLATE IV.



(a) The lounge of a privately-built home belonging to a nursing sister and her husband, exemplifies elite living standards.

(b) Having completed her work for the morning, the maid relaxes in the kitchen of a staff nurse's home.

expensive furniture in every room, while the family virtually lives in the kitchen, a situation I have witnessed in the house of a successful trader married to an ex-teacher, for example. As one of Brandel-Syrier's informants notes:

> "'A house is not everything; you must know how to live in it.'" (Brandel-Syrier, 1971:58)

Conspicuous consumption among elites has been noted in many parts of Africa, and to the extent that they regard it necessary to live in a manner befitting their high status, it is found among African nurses as well. In the African community, a member of the elite would lose status if he or she did not live in the manner expected by the rest of the community: this is probably true in most societies. However, the furniture and clothing (in terms of which conspicuous consumption is evidenced), bought by African nurses, is considered by them to be necessary for use, not for show as such. Elements of conspicuous comsumption are far more evident among those striving to attain elite status, than among those who already have it. The elites use their possessions: the aspirant elites acquire similar possessions in order to lay claim to similar status. This policy of conspicuous consumption among aspirant elites reflects what Nadel (1956) terms the "imitability" of the true elites.

The imitability of nurses, as elites, is evident in more than their houses and furniture, however. Nurses are innovators in the realm of dress and fashion: as Kuper (1965:113) states, "African nurses, in particular, set an example in glamour and elegance". For instance, in Durban recently, Afro wigs have enjoyed increasing popularity since the introduction of this fashion by young staff nurses. Likewise, mini-skirts have been adopted by young, presumably urbanised, African girls, particularly office workers. However, nurses still have a virtual monopoly over the wearing of slacks and trouser

suits, at least in Durban, and this monopoly is related to values, for only those women who are committed to the "western way" would dream of wearing a type of dress traditionally (in western society, that is) the prerogative of men.

Beyond the realm of fashion, the leisure activities of nurses are also innovative, and provoke great interest in the African community. When a nurses' ball is held within hospital grounds, for instance, the doors must be guarded to prevent the mass entry of patients and domestic workers, who display tremendous interest in the proceedings. (I have witnessed such a situation at Nqutu, in rural Zululand, as well as in Durban.) Ballroom dancing, at which nurses excel, is, of course, an extremely prestigious leisure activity. But even handwork, especially crochetting, is closely associated with nurses as a group, and their example in this field is followed by, among others, domestic servants. Preston-Whyte (1969:312) states that:

> "Embroidery and crochet-work...were regarded as smart and indicative of a certain discernment and even, by some women, as a sign of respectability and what may be termed 'class'."

Thus nurses, as elites, set standards (of dress, housing, furnishing and leisure activities) that are imitable by other, non-elite Africans. As will be shown in a later chapter, these standards are not restricted to material possessions, but go further and involve attitudes and values, for the nurse regards it as her duty to "educate" the uneducated -- that is, to inculcate her own values into others.

However, while nurses are actively promoting change in African society, through their innovations, it must be noted that not all members of the African community accept their lead. Essentially, nurses, and other elites, divide their society into two sections, one of which finds their example

acceptable, and imitates it, while the other section rejects their innovations. As Nadel (1956:420) writes:

> "...when traditional and anti-traditional conceptions come into conflict...the existence of the elite...is proved when the 'new men' claiming pre-eminence in fact succeed in 'setting standards' accepted by others, and thus divide the society, if only for a period."

Thus the example upheld by the elites, is unacceptable to "traditionalists in Africa today, for their example is a rejection of traditional values and behaviour. For instance, nurses reject emphatically the idea of patrivirilocal marriage, and express a preference for small families, to which end they utilise modern contraceptive techniques: both of these practices negate traditional African values. However, even though part of the African population does not accept their lead, it seems that even the traditionally-oriented respect the elites, and adhere to general community expectations regarding elite behaviour, even though they do not aspire to follow the example set by the elites. Thus, although the elites are the standard-setters, they are, to some extent, bound to conform to community expectations, or else run the risk of losing prestige and status in the eyes of all, including the uneducated.

(c) Stereotypes.

A system of stereotyping, using what are ostensibly kinship terms, is applied by nurses to different sections of the uneducated stratum of African society. The stereotypes differentiate among sections of the uneducated masses, on the bases of age and sex.

Except for the very old (to whom the Zulu term gogo: grandmother is applied), uneducated or less well educated women are usually referred to as aunties. Any woman a nurse calls auntie to her face, will be older than the

nurse, though occasionally they may be of the same generation. Aunties are conservative in appearance and manner. The term auntie, from its English derivation, would appear, on the surface, to be respectful but time-saving, since it is used frequently in hospital wards and clinics, to patients. But despite its outward connotations of respect, auntie is applied to a category of people for whom the nurse has little time or respect, as is evidenced in the following quotes from informants.

> "The aunties wear these long skirts -- look, you can see them now (indicating through the window). You must wear a skirt at least down to here (indicating mid-calf) or they say you are very immoral! Mostly the aunties are raw people from the country. Even though they may be Christians, still they think as our people used to long ago...
> Now you see from what I am wearing today (a skirt and blouse of similar dark colours, though not proportions, to those worn by the group indicated), Thomasina (her staff-nurse neighbour) was teasing me that I must join the aunties!"

> "Auntie, you are much, much too fat. How many children? TEN?? (Turning to anthropologist) Hau! Aunties never learn! (at ante-natal clinic.)

The nurses' reaction to the aunties must be seen in the context of the nurses' adaptation to a culture that is anti-traditional. The nurse role has no place in traditional African society, and it is in the nurses' own interests, then, to avoid being identified with attitudes and values which belong in the traditional, or at least semi-traditional, setting. Such identification with traditional culture would detract from the elite status of the nurses: I have already mentioned that one of the nurses' reasons for regarding teachers as having a lower social status than the nurses themselves, relates to the teachers' (alleged) greater conservatism. However, it is also possible that part of the conflict between nurses and aunties, stems from the fact that they belong to proximate generations.

Aunties are, then, uneducated women somewhat older than the nurse who is

using the term. The corresponding term for men who are somewhat older than the nurse, is buti (from the Afrikaans boetie: little brother) or uncle, but neither of these terms is used with any frequency. In general, nurses seem to avoid calling uneducated men who are slightly older than themselves, by any term at all. However, an uneducated man who is considerably older than the nurse, will invariably be called baba (the Zulu term for father). The combination of age and masculinity appears to balance out lack of education, for nurses show deference to elderly, uneducated men, in normal circumstances. Perhaps this deference reflects the strength of the patrilineal idiom in Nguni society, even today.

The elderly woman (gogo), on the other hand, is regarded by the nurse with a mixture of deference and exasperation. Her age entitles her to respect, yet her lack of education, adherence to traditional beliefs and behaviour, and frequent refusals to follow the nurse's instructions, irritate the nurse in much the same way as do the aunties. Kuper (1965:224) quotes one nurse as saying:

> "'Uneducated women are the worst patients. If they are older than we are, they don't like us for telling them what to do, and if they are our age, they are jealous of our position.'"

It is perhaps significant that nurses apply stereotypes to uneducated people who are older than themselves, but that the younger generation of the uneducated stratum is not stereotyped (with the exception of the tsotsi's). Perhaps this age differential in stereotyping is a result of the ambivalence of the nurse's position with respect to uneducated members of older generations. As a result of her professional occupation, the nurse's social standing is higher than that of the aunties, gogo's, uncles and baba's. In terms of traditional expectations, however, the nurse is younger than these people, and her status should, therefore, be lower. The nurse reacts slightly differently,

then, to each of these sections of the uneducated stratum, according to the strength of their claims to deference from her, on the basis of age and sex. But as far as her own and younger generations are concerned, the nurse is superior in terms both of occupation and age. Only those uneducated young men, who challenge the nurse's claim to social superiority on the basis of her (traditionally inferior) status as a woman, are stereotyped as tsotsi's, "...'who respect nobody'" (Kuper, 1965:224).

I have shown, in these sections, how African nurses mark themselves off from the rest of the African population. Their friendships stress their elite identity and, more specifically, their identity as nurses within the elite stratum. Their life style and material possessions set them apart from the non-elites, who imitate them, to some extent. And the nurses' system of stereotyping and categorising various sections of the uneducated, non-elite masses, demonstrate, in some detail, how and why nurses differentiate themselves from particular sections of the uneducated African population. In the next section, I shall examine how this differentiation of nurses from both non-elites and non-nurses among the elites, operates within the context of membership of voluntary associations.

Association Membership among African Nurses.

During the course of my research, I gained the general impression that the majority of African nurses are not particularly interested in joining clubs and societies, although I cannot support this impression with detailed statistical data. However, only a small proportion of nurses are actively involved in the affairs of the local branch of their professional association; fewer still belong to sports clubs; and although the vast majority claim affiliation to an orthodox Christian church, relatively few are active in

church affairs either. The nurses' emphasis on their privacy is, to some extent, incompatible with widespread membership of voluntary associations: I shall return to this point later. However, even though there is relatively little active participation, particularly in the affairs of the professional nursing association and church activities, what one might term latent membership, or non-active affiliation, does reveal some important aspects of elite status. Thus active or passive affiliation to certain organisations, is significant.

(a) Professional Association: The Ogwini Branch[1].

In South Africa, it is legally obligatory for all practising registered nurses to belong to the South African Nursing Association. African members at present pay R6,00 per annum for their membership, which includes voting rights, and the South African Nursing Association has the necessary powers to sue any members who may be in arrears with their subscriptions. Furthermore, many hospitals, particularly provincial hospitals, demand proof of payment by submission of receipts, and in cases where these receipts cannot be produced, sanctions such as forfeiture of one's leave bonus, or even termination of employment, may be applied. But although nominal membership is thus enforced, active participation in the affairs of the South African Nursing Association, is voluntary, in the sense of being left to the individual's own discretion.

The local branches of the South African Nursing Association are triplicated along racial lines, and are all ultimately controlled by the S.A.N.A. Headquarters, in Pretoria, under the direction of the Chairlady, Organising Secretary and the Executive Board. Of some thirty-one African local branches, four are in Natal and Zululand, and these are based at Stanger, Dundee, Pietermaritzburg and Durban. The Durban-based Ogwini Branch stretches beyond the city itself, to include nurses working at all health institutions

[1] See Appendix III: "Procedure Adopted for the Ogwini Branch" (Constitution).

from Durban to beyond Port Shepstone, and inland to Botha's Hill.

The establishment and organisation of each local branch depends upon the members of the South African Nursing Association in that particular area. So the move to set up a local branch depends upon the initiative of nurses working in that area, and once the South African Nursing Association has approved the formation of a new branch, and the Organising Secretary has assisted in its inception, the running of the branch is the responsibility of the nurses themselves. Each branch elects office bearers at regular intervals, usually annually. The Ogwini Branch has an Executive Committee of eleven members, including the Chairman and Vice-Chairman, Secretary and Assistant Secretary. Three members of the Executive Committee are jointly responsible for financial affairs and may, at times, be controlling income and expenditure totalling many hundreds of rands (derived from concerts, picnics, jumble sales and other fund-raising activities), as happened when the Ogwini Branch organised the 1970 Biennial Congress for African members of the South African Nursing Association.

Belonging to such an association, which is effectively controlled by Africans, and yet has strong ties of affiliation with Whites -- and, therefore, official recognition -- obviously has elitist value, but this is tempered by South African circumstances. African nurses, especially those who are not actively involved in S.A.N.A. affairs, express antagonism to what they regard as a "stooge" organisation geared primarily to White interests. Perhaps this is inevitable in view of the overall structure of the South African Nursing Association, stipulated in the 1957 Nursing Act (As Amended). Bluntly, this negative attitude reflects racial antagonism, very often on the part of African nurses who have, in the past, been disillusioned with the apparent failure of the Board of the South African Nursing Association, to improve

conditions for African nurses. The following quotation illustrates this point:

> "We do not doubt your sincerity, but looking at the salary gap between the White and the non-White races, one tends to fear that one is seeing what one would not like to see: that the Board is 98% behind the other people, and maybe 2% behind the Africans.....Which of course is not so. But I am trying to show that, if one just looked at the figures, it would give that impression."[1]

The majority of African nurses who do not attend branch meetings, and who express lack of interest in the affairs of the South African Nursing Association, echo this attitude, rather more vehemently, and regard active support of their professional association as a waste of time in terms of results. But this is not the only reason for lack of participation. One cannot always be off-duty when meetings are held, and even when they are off-duty, African nurses (like other people) have multiple claims on their spare time, especially those nurses who are married and have families. Nurses in different age categories have differing leisure-time interests, and attending meetings is not usually a leisure interest of younger nurses. Finally, there is also the age-and-authority factor.

Respect for one's chronological seniors is important in African societies, perhaps more important than in most others; and the nursing profession itself is highly stratified on the basis of rank, which normally coincides with age grading. When a young African nurse is in authority over her rank juniors but chronological seniors, she is in a situation that is (at least potentially) tension-laden, because the expectations of her professional role conflict with those of her age. Within the all-African structure of the local branches of the South African Nursing Association, the positions of authority are held by the older generation of nurses, to a degree quite disproportionate to their numerical strength (or weakness) in the profession as a whole. Only 25,4% (57

[1] From a delegate's speech at the 1970 Biennial Congress.

of 226) of questionnaire respondents were over forty years of age, yet I knew of only one member of the Ogwini Branch Executive Committee who was under forty. In this situation, where authority in the affairs of the professional association, is vested in the older generation, few young nurses (who hold staff nurse or junior sister rank in the work situation) are interested in subordinating themselves to the senior generation of ward sisters and matrons, outside the work situation. These younger nurses prefer to spend their time listening to records, dancing, shopping, playing sport, going to the beach -- rather than attending meetings which usually last for at least three hours, and discussing matters which involve financial outlay for no readily apparent returns (such as donations in the name of the branch, financial support of retired nurses, and so on).

There is one other factor involved in the dominance of older and senior-ranking nurses in the affairs of their professional association, and this is the distinction that can be drawn between old and new elites. The older nurses belong to the generation having extensive and intensive contact with the missions[1]. They are mission-educated and, in the majority of cases, mission-trained as nurses, and perhaps they may be regarded as part of what Mercier (1956:448) has termed the "colonial elite". The younger nurses, on the other hand, have had a more protracted school education (in secular institutions) and a more modern training: they may thus be regarded as part of the "intellectual elite"[2]. Between these two sections of the elite stratum, in most occupations, there exist certain differences in interests and attitudes, which are related to the slightly different socialisation processes. Thus

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[1] The religious background of the Ogwini Branch organisers, is apparent in branch meeting procedure. Meetings are always opened with a prayer, in English, by a member.

[2] By "colonial elite" Mercier means those with post-primary education, who have stable and secure civil service positions. The "intellectual elite" comprises highly educated professionals, and has largely arisen since the second World War, in Africa. Conflict between the two often stems from the situation where the lesser educated "colonial elites" hold the higher posts, simply because they were available earlier, when the positions became available.

one finds, among nurses, that the older nurses have "stabilised" their position in society, since they do hold the posts of authority, and would appear to have lost much of their motivation to introduce change. On the question of salaries, for instance, the older nurses accept that government policy decrees differential salaries for Black and White, and while they are prepared to fight for better salaries within the Black scales, they are not prepared to risk their own positions by demanding parity in salaries, between Black and White, as the younger nurses do. This is not to say that the older nurses agree with the principle of differential salaries: merely that they stand to lose what they have achieved, and therefore do not support moves for radical change. The younger nurses, on the other hand, dismiss the policy of gradual change, which is supported by the older nurses, as being unworthy of their support, since the results of gradual change are, for them, unsatisfactory.

Despite the general lack of support from African nurses, however, the activities of the Ogwini Branch show concern not only with professional interests, but also involve nurses in their relationship to the wider African community. The African nurse, through her membership of a common professional association with Whites, has the possibility of using this position to improve both her own position and conditions within the African community. Some of the resolutions tabled at the recent nursing congress illustrate this attempted manipulation of professional ties, for ends that are not strictly professional. It was proposed:

> "That the Board of the Association be asked to assist nurses in installing telephones in their homes."
>
> "That the Board of the South African Nursing Association makes representations to the authority concerned to relax the regulation whereby the homes of widowed and divorced nurses are repossessed in townships governed by township authorities."
>
> "That the Board of the South African Nursing Association

> investigate the possibilities that nurses be exempted from curfew laws."

While these three resolutions are directly concerned with the elite interests and legal status of African nurses, even though they do not relate directly to professional issues, the following proposals have still wider referents:

> "That representations be made to the appropriate authorities for the establishment of crêches for the children of hospital employees."
>
> "That representations be made to the Department of Bantu Education for compulsory education to at least standard 6 for all non-White groups."
>
> "That representations be made for the establishment of special centres for the treatment of drug addicts and alcoholics."
>
> "That the Board of the South African Nursing Association make representations to the Department of Bantu Administration for the granting of rebates to Bantu tax-payers in respect of children and dependents."[1]

The use to which African nurses put their professional ties with their European colleagues, and particularly their membership of a common professional body, is thus quite evident. These links offer the possibility of occasional manipulation of the South African (White) bureaucratic structure, to the advantage of African nurses in particular, and the African population in general. In their role as initiators of this manipulation, the nurses stand to gain prestige. To the best of my knowledge, with the exception of the medical profession, there is no other occupation in which Africans have such possibilities for manipulating the controlling (European) professional authority, for their own ends or for the good of the community: for if nurses,

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[1] Resolutions for Discussion at the 7th Biennial Congress for Bantu Members of the S.A.N.A.: B.C.B. 8 - 6/70: nos. 3; 17.3; 17.4; 19; 21.6; 23; 25.

no matter what their racial classification, pass a resolution at one of these congresses, the Board of the South African Nursing Association is bound to act upon it.

Although most African nurses do not afford their professional organisation very much support in the normal course of events, they do, however, identify with large-scale activities of the local branch. During the period of preparation for the 1970 Congress, and at the Congress itself, active branch members could and did call upon the assistance of hundreds of nurses in the Durban area, most of whom would not support the branch normally, and who gradually dropped out after the Congress was over. Likewise, picnics at Umgababa (an African South Coast resort), and a visit, in uniform, to Kwa Magwaza, to attend a Nurses' Day church service (organised by the North Coast branch), were also well attended. The most obvious reason for this identification with the professional nursing association for public and even ceremonial occasions such as these, lies in the prestige accruing from such public events, which receive newspaper coverage, even in the European press, on occasion. Such support in the face of publicity, must be regarded partly as an assertion of status, whatever other factors may be involved.

The professional association is thus partly responsible for the nurses' elite status within the African community, and this status is reinforced periodically by public gatherings of African nurses, of the type mentioned above. But the identification of African nurses with their colleagues is not restricted to activities of the local branch of their professional association: it is also demonstrated in their membership of other voluntary associations, especially church groups.

PLATE V.

(a) An exhibition of handwork at Clairwood Hospital shows why African nurses are renowned for their skilled crochet-work.

(b) Durban, 1970: delegates to the Seventh Biennial Congress for African members of the South African Nursing Association, listen attentively to a guest speaker.

(b) Religious Affiliation.

In common with other educated African elites, nurses belong almost exclusively to orthodox Christian denominations. Most belong to African branches of European churches. Some belong to African churches that are now independent of their parent mission bodies, such as the United Congregational Church, which was originally part of the American Board of Missions. These independent churches remain orthodox in creed and ritual, however. Only a tiny minority of African nurses belong to unorthodox, separatist churches and little-known sects. As may be seen from table 3, nearly 78% of the questionnaire respondents (176 of 226), belonged to the four major denominations of Catholic, Methodist, Anglican and Lutheran, this affiliation being partly related to their missionary educational background.

TABLE 3. Religious affiliation among African registered nurses[1].

Catholic	56
Methodist	51
Anglican	44
Lutheran	25
*United Congregational	17
Presbyterian	7
American Missionary Board	5
*Bantu Methodist	2
*Bantu Presbyterian	2
Dutch Reformed	2
Baptist	1
Church of Paris Mission	1
Congregationalist	1
Full Gospel	1
*Assemblies of God	1
*Church of God of Prophecy	1
*Church of Zion	1
*Ethiopian	1
*Pentecostal Protestant	1
*Twelve Apostles' Church	1
Unknown	5
TOTAL:	226

[1] * indicates independent status.

This membership of churches linked both in origin and ritual to European organisations, is tacit affirmation of the point made in chapter two, that elite status rests largely on participation in the new, western-based, modern cultural system. Although African women normally assume their husbands' church affiliation after marriage (where this does not already coincide with their own), I know of one nurse who flatly refused to affiliate herself, even nominally, with the Zionist sect of which her husband was a (nominal) member. Since her husband refused to let her continue her former Methodist affiliation, this nurse attended no church at all rather than keep company with Zionists. Particularly telling, in terms of elitist values and behaviour, is the following quotation from one nurse on the subject of Shembe's church.

> "And the son...he has a B.A. degree, and look at what he is teaching the people. They pray to Shembe, not to Jesus... And the dancing and the beer-drinking! He is not educating the people. That is not progress. He is dragging them back to how the Zulus used to live. No, that is very bad, especially for an educated somebody."

The behaviour of Zionists, especially, is regarded as being unacceptable to a nurse, incompatible with her whole outlook. Not only is Zionist behaviour and religious interpretation regarded askance by nurses, but the fact that Zionists are thought of as uneducated and dirty, removes them from the nurses' potential sphere of social interaction. To associate with such people would cause gossip and detract from their high prestige. And, of course, the nurses' ideas on the subject of disease causation and healing differ radically from those of the Zionists (as well as those of many of the non-medical elites, one suspects).

Most orthodox African churches have <u>manyano's</u>, or Mothers' Unions, the equivalent of the European Women's Guilds. These organisations provide the means through which women may feel that they are playing a significant role

in the life of the church to which they belong. In the main, the women who belong to these manyano's are non-working wives, or perhaps they hold some type of unskilled or semi-skilled job, such as domestic service. They tend to have a fairly low standard of education, and some may be illiterate. They are conservative, both in behaviour and ideas. They are, in the nurses' terminology, the aunties, and a very clear distinction is drawn between nurses and aunties, as has been indicated previously. It is not surprising, then, to find that nurses, with very few exceptions, do not belong to the manyano's.

This is not to say, however, that many nurses do not lead actively religious lives. Probably the majority of them attend Sunday church services when they are free, and some of the provincial hospitals, as well as the mission hospitals, have regular chapel services conducted by visiting ministers of different denominations. Of those nurses who are regular church-goers, many deplore the fact that they "don't have enough time" to attend manyano meetings, which are usually held on Thursday afternoons -- admittedly a difficult time for most nurses to attend on a regular basis. However, I submit that this excuse based on lack of time, is often a front which conceals the nurses' unwillingness to put themselves into a position of equality with, or even subordination to, the aunties. Indeed, this is recognised and admitted by certain nurses who have considered the situation at length. The situation in the Catholic church illustrates the point.

Within the organisation of the Catholic church, the mothers are those who have a special dedication to St. Anne. The St. Anne group (manyano) in each mission centre, is organised under the leadership of a chairlady and secretary, plus other committee members, who are elected at regular intervals. Invariably, so Catholic nurses tell me, the people who are elected to these positions are aunties, and they are accorded great deference by the rank and

file members. As the nurses say, they are not prepared to "bow down" to these aunties, and so the nurse who belongs to the St. Anne's group is a rarity. None of the Catholic nurses I met, knew of any nurse who is a member of this group, although African teachers are, apparently, members.

However, nurses couch their reasons for not joining the St. Anne's group in terms of their limited free time. The woman who joins the St. Anne's group is required, apparently, to undertake certain vows, and the nurses say that they cannot commit themselves as strongly as these vows require, because they do not have the time. Therefore, they do not join the group. Instead, they are caught up in the activities of the Catholic Nurses' League, or Guild.

Significantly, in terms of time commitment, contributions and activities, there appears to be little difference between the St. Anne's group and the Nurses' League. Both are concerned with chasing up laggard Catholics, fund raising, doctrinal instruction, prayers and religious study. Members of both groups are expected to visit the sick, though this requirement is less strictly enjoined upon the nurses! The funds that both collect are used for charitable purposes, such as assisting destitute individuals and families with food, for short periods. Significantly, the nurses also use their "purse" to educate Catholic orphans, who are expected to repay the "purse" later[1].

The only real difference between nurses and aunties in their respective organisations within the Catholic church, is that nurses are not required to make any vows regarding their commitments. This may well be a result of the assumption that their social conscience, by virtue of their occupation, is more highly developed and less in need of spiritual reinforcement. In any case,

[1] The Ogwini Branch of the South African Nursing Association, has recently voted to "adopt", for educational purposes, a poor child in the Durban area, and finance that child through school until he/she obtains at least the Junior Certificate. Is this type of commitment to education another specific index of elitism?

both the establishment of a separate organisation catering exclusively for nurses, and the waiving of the vow requirement, are indications that nurses constitute a significant and even unusual group, and this concession on the part of a formal organisation as important as the Catholic church, is itself an indication of the nurses' elite status.

Whereas the Catholic church has made separate provision for nurses in organising formal women's groups, and has thus retained the nurses within the Catholic framework, other churches have neglected this approach. Consequently, nurses in the various Protestant churches, who are interested in active participation in religious associations, generally belong to the Young Women's Christian Association (Y.W.C.A.), which organises both social and religious functions from its headquarters in Beatrice Street, in the centre of Durban. Not only are dances, dancing classes, indoor sports and music evenings arranged under the auspices of the Y.W.C.A., but fund-raising for charitable, including educational purposes, is also important. Of the active members of the Ogwini Branch, particularly those belonging to Protestant denominations, many belong to the Y.W.C.A. as well.

(c) Other Voluntary Associations.

Apart from the professional and religious organisations discussed above, a few nurses belong to sports clubs. Those who do are mostly single and in the late-twenties to early-thirties age group. Almost exclusively, they belong to tennis clubs and, as Wilson and Mafeje (1963:125) note for Cape-Town:

> "Tennis is a game of the ooscuse-me and the numbers involved are small."

Membership of other types of voluntary association is, to the best of

my knowledge, unknown among African nurses. Insurance policies, for instance, fulfil some of the functions of the umgalelo clubs described by Wilson and Mafeje (1963:114), and socialising among the nurses, as part of the elite stratum, is effected on the basis of personal friendships. It does seem that interest in joining voluntary associations, is low among African nurses. Individualism and what might be termed the "cult of privacy" appear to dominate the attitudes and behaviour patterns of the nurse-elites, for reasons which will be discussed in the next chapter.

An Ideology of Corporateness: A Brief Note.

I have attempted to show the ways in which certain values and attitudes influence, if not determine, the limited interest in association membership displayed by African nurses. By definition, nurses form a fairly corporate professional grouping, which is reflected, to some extent, in the activities of nurses in the South African Nursing Association, and its local branches. But nurses do not, in general, form easily identifiable, corporate social groupings. Generally, nurses tend to exhibit disinterest in formal social organisations, and it is very difficult to demonstrate "corporateness" among African nurses in terms of their social behaviour -- except for their friendships with other nurses, and the existence of the Catholic Nurses' League. However, there is evidence to suggest that an ideology of corporateness exists among nurses, even if this is not always displayed in actual behaviour.

And perhaps an ideology of corporateness is, in itself, more significant than overt social alignment, particularly for an elite group, for, as Nadel (1956:416) points out:

> "...for the 'wealthy' to be an elite (rather than a mere class of people) it is not necessary that they should be organised in a Rich Men' Protection Society or a Millionaries' Club:

> but their actions and the exercise of their particular superiority must follow from the premise 'We, the wealthy...'"

Indeed, the beliefs, thoughts and perhaps even the actions of the African nurses I knew, could well be said to follow from the premise "We, the nurses..." or "I, as a nurse...". The close identification of nurses with other nurses results, at least in part, from their common socialisation into the nursing profession, and is seen in the various ways in which nurses differentiate themselves from the remainder of African soceity, as well as in their "positive identification" with other nurses in some formal associations. Yet even though nurses do differentiate themselves from the rest of the African population, elite and non-elite, they are linked to the non-elite community in a number of ways, which will be discussed in the next chapter.

CHAPTER FIVE

LINKAGES IN THE SYSTEM OF SOCIAL RELATIONSHIPS

While the differentiation of African elites from the general population is quite marked, the links between elites and non-elites are, perhaps, equally noticeable. Particularly in South Africa, there is little residential segregation of elites and non-elites, such as exists in most other African countries. Furthermore, nurses, in particular, spend their working lives in close physical contact with their predominantly non-elite patients, for they work with and among the masses. Finally, as has been reported from most other parts of Africa, the elites have consanguineal and affinal ties with those who are uneducated, and such kinship ties are not always easily broken. All such relationships with non-elites may be seen within the elites' own framework of responsibility to share their knowledge with those, whom they regard as less fortunate than themselves, who are not educated.

African nurses are well aware that they constitute part of the educated stratum of African society, and they regard it as their responsibility, as educated people, to dispel ignorance among their uneducated fellows, especially those to whom they are personally linked. The words of delegates to the 1970 Congress, speak for themselves.

> "...And our jobs, educating others, thinking of ourselves as the trained nurses of the community. We have to remind ourselves, we have to be reminded, that we have to try our best to attain the aim of educating our patients..."

> "...So I am confident that the nurses will help the community by educating them to know what is right and what is wrong..."

> "When you meet somebody in the street, that person does not need to be ill to be a patient. As we all know, in community health, prevention is better than cure, and even if that

> person is not requiring a cure, every human being is a patient as far as the nurse is concerned. You are there to give advice. You are there, not to criticise, but to tell them, in a very fine bedside manner, what ought to be done and what ought not to be done..."
>
> "The African is looking from traditional guidance and ways of living, to the modernised way of <u>health</u>."

In stressing that they are in a position to "educate" the uneducated, African nurses are, in effect, asserting their own imitability as far as knowledge and values are concerned. When examining African nurses' relationships with non-elites, one must bear in mind that an awareness of their own imitability (which Nadel (1956) does not mention), appears to be particularly important where elites are attempting to foster acceptance of a new cultural framework at the expense of the existing one. Thus elites use their personal relationships with non-elites, to promote acceptance of their own ideas and values. An examination of nurses' relationships with certain categories of non-elites, gives some idea of how elites may and do use such relationships to promote their own imitability.

<u>Non-Elites Outside the Kin Network: Patients, Neighbours and Domestic Servants.</u>

Because the nurse-patient relationship is structured and formalised, the "educative function", or imitability, of the nurse is rarely apparent in this relationship. However, as part of their authority role over patients, nurses are expected to teach patients whatever they should know concerning diet, hygiene, and so on, with specific reference to their particular diseases. Hence it is probable that the African nurses' self-confessed responsibility to "educate the people" stems from the expectations of the professional nurse role, at least in the initial instance. The nurses' imitability is, however, seen more clearly in their relationships with neighbours and domestic servants

than in the professional nurse-patient relationship.

In South Africa, the process of residential segregation of elites, in elite suburbs, has been less marked than in other African countries[1]. Elites in South Africa mostly reside among the rest of the population -- the wealthy among the poor, the educated among the illiterate, the respectable among the less respectable. While this situation appears to have fostered the emphasis on privacy found among South African elites, it has also resulted, in some cases, in elites deliberately "educating" their neighbours.

One particularly clear illustration of the educative function or imitability of African nurses, and how nurses themselves promote this imitability, occurred during the course of my fieldwork. In one of the newer sections of Umlazi township, land available for individual purchase and private building, is intermingled with plots on which township houses have been erected by the government housing authority. One of the private stands had been bought by my informant, a nursing sister at a provincial hospital, and her husband, a relatively high-ranking member of the South African Police, who was previously a teacher. They had built privately on this land. Immediately next door, in an ordinary four-roomed township house, lived an unskilled industrial labourer, his wife, and their family of six girls: a seventh child was expected shortly. In this house, the sparse furniture had been made by the man himself (he had once assisted a White carpenter). However, the house itself was spotlessly clean and tidy, as were the shabby clothes of the woman and her daughters. My informant showed me around this house with great pride, telling me of the frequent requests to her for advice and, occasionally, assistance with food and money. Finally, <u>en route</u> back to her own beautifully furnished, three-bedroomed house, she said:

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[1] To the best of my knowledge, Dube Village (Soweto) is the only truly elite African suburb in the whole of South Africa.

> "I am so proud of that woman! Even though they do not have money -- I would never manage on what she does -- still she has learned so well what I have tried to teach her about hygiene and cooking. It is a pity that they have so many children, but you know our Zulu custom that there must be a boy in the family...I hope the child she is expecting is a boy, or else the husband will insist on trying again! And you can see they are poor. Another child will be <u>too</u> much..."

However, while nurses may be approached by their neighbours for advice and assistance, there is usually little direct contact between nurses and their non-elite neighbours. As I have already mentioned, nurses tend to hold aloof from the activities of public associations and societies, and place great emphasis on their privacy. I would suggest that at least part of their reason for withdrawing from the public eye, lies precisely in the residential integration of elites and non-elites in South Africa, which might, perhaps, be expected to encourage social integration. For nurses, along with other educated Africans, are subject to certain community expectations regarding their behaviour. As Wilson and Mafeje (1963:79) note, for instance:

> "'If a staff nurse lived with a lover, openly, the whole of Langa would know about it immediately.'"

Where elites and non-elites are residentially integrated, the news of misbehaviour on the part of elites spreads rapidly, threatening to bring entire categories into disrepute, which in turn could lead to loss of prestige. Thus the elites stress the value of privacy and keep to themselves. It is my impression, from the literature dealing with elites in West Africa, and from my own research experiences in South Africa, that the social distance between elites and non-elites may be greater in South Africa than in West Africa, where residential segregation of elites and non-elites is well-defined. Thus, although the imitability of elites may be more readily apparent, more overt, in situations where they are living cheek-by-jowl with non-elites, this situation may also make the elites more aware of the

necessity to remove themselves, socially, from interaction with non-elite neighbours.

However, while interaction with neighbours may be cut to a minimum, there is one category of non-elites with whom nurses, in particular, interact extensively: their domestic servants. The servant virtually becomes part of the nurse's family. She lives with the family, shares their food, assumes many if not most of the mother's functions vis-à-vis the children. Indeed, the domestic servant usually calls her nurse-mistress "sis", a term which Vilakazi (1965:41) states has derived from the Afrikaans "sussie" (meaning "little sister"), and which definitely denotes a pseudo- or fictional kin link in this context[1]. This fictional kin link is one means of binding the servant more closely to the nurse, and stresses the obligation of the servant in this relationship. Such a link is necessary, for the problems involved in employing and retaining the services of a competent maid, are ones with which the African nurse, like the suburban European housewife in South Africa, is only too familiar. As one of my informants stated:

> "We take them into our homes, and treat them as one of the family. They eat the same food that we do, sleep on our beds, and still they abuse us. We teach them how to iron, and cook, and clean properly, and the next thing -- they are gone! Sometimes they even just walk out, and we do not know that they are gone until we come home and find a dirty house, and no food prepared, and the children tell us. They say that they want to go and work for the Europeans, but we treat them just as well as they do."[2]

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[1] It is interesting to note that the term "sis" (which is used only by the servant to the nurse, and not symmetrically), implies an "egalitarian" relationship, which does not exist. Perhaps this term "sis", in addition to stressing the obligations of the servant role (in the traditional idiom of kinship?), is a means of reducing tension in the nurse-servant relationship, in which the nurse wields recognised authority, by allowing the servant to verbalise, or to assert verbally, a status of equality with the nurse. Perhaps the nurse is prepared to permit such (verbal) equality, as long as she is in control of the elite-non-elite relationship, and her higher status is not disputed. Relations with aunties contain no such egalitarian implications.

[2] Preston-Whyte (1969:200) notes, from the servants' point of view, there is no prestige, in terms of contact with the dominant (European) culture, involved in working for Africans, elites or otherwise.

Two of the possible solutions to the problem of retaining the services of a maid, are to employ either a kinswoman (preferably in a known, rather than classificatory, relationship), or else a member of the same church congregation. Three of my regular informants had employed kinswomen, and two others has gained the services of fellow-worshippers. The rest of my informants were struggling to solve the problem, and expected to have a new maid every two months or so. When a kinswoman or fellow-churchgoer is employed, of course, certain sanctions operate to tie the servant in a fairly close relationship to the nurse (as a high-status member of a closed group to which they both belong), and to lay her open to correction from those with whom she interacts, should she not fulfil her duties adequately.

The nurse deliberately inculcates into her domestic servant, her own values and practices, ideas and behaviour. She teaches the servant to run a modern home, emphasising the importance of hygiene and child care, diet and budgeting. The knowledge she imparts is not solely concerned with ensuring her own material comforts, for the servant is expected to apply what she has learned from the nurse, to her own home when she marries. The benefits to the servant of such teaching, are regarded by the nurse as long-term: one of the ways in which she can and does "educate the people" is through the series of domestic servants she employs.

In this situation, where elites deliberately teach others to follow their example, thus promoting their own imitability, it is highly probable that one of the most important ways in which their ideas and values permeate the general community, is through those women who work for them. In other words, members of the elites' (in this particular case, nurses') <u>effective</u> social networks, may be as important as those on the periphery of their extended networks, in disseminating information on elite life style to the

masses. Epstein (1961) does not appear to have considered this possibility, for he states (1961:59):

> "I suggest that new norms and standards of behaviour will tend to arise more frequently within the effective network of those who rank high on the prestige continuum, and that through the extended network they gradually filter down and percolate through the society."

While I have no quarrel with this suggestion, my own research experience leads me to suggest that the norms and standards of behaviour acquired by African nurses' domestic servants (who must be rated as members of the nurses' effective networks, on the basis of the data given above), may be transmitted to members of the servants' own effective networks. It is possible that norms and values thus filter down from one effective network to the next, transmitted (in the initial instance, at least) by low-status members of the network. In this model, it becomes necessary to visualise one person moving between discrete effective social networks, thus establishing communication between networks of decreasing status order, in addition to visualising increasingly tenuous links connecting people in the extended network. Obviously, both of these models have explanatory value in the context of the dissemination of new norms and values through the society, for while servants are part of the nurses' effective networks, non-elite neighbours can only be regarded as part of the nurses' extended networks, in terms of actual interaction.

The social networks of African nurses' domestic servants constitute one channel of (largely one-way) communication between elites and non-elites, but the nurses' own kin networks are also important in this respect. Biologically close kin form an important part of the nurses' social networks, whether or not such kin may be regarded as elites. Thus domestic servants and uneducated kin may be regarded as points of articulation between elites and non-elites: they are factors common to the systems of social relationships of elites and

non-elites alike.

Patterns of Kinship: Consanguinity.

The data on which much of this section rests, are the genealogies[1] of nine of my regular informants. These nine cases are not necessarily representative of African nurses in general, and the very small number of cases does not warrant firm generalisation. However, the points that emerge from an examination of these genealogies, do appear to have wide applicability among African nurses.

The first point of interest pertains to the actual numbers of kinsfolk recalled by these elite nurses. Even though many kin links have been attenuated with the geographical dispersal of members of kin groups, African nurses recognise large numbers of kin, patrilateral and matrilateral. This recognition would appear to suggest that kin ties are not easily forgotten, even if they are not activated. Table 4 draws a distinction between the minimum numbers of kin these nurses recognise (that is, all those persons who appear on their genealogies), and the numbers of these recognised kin whom they can actually name. As may be seen from table 4, there is a tendency for the older nurses to come from the larger kin groupings. While this tendency is undoubtedly partly a function of the stage of the developmental cycle of each family group, it does seem possible that there may be a decrease in the sizes of sibling groups with the spread of literacy, since it is the younger nurses who have parents that are both literate. In other words, it may be that the younger nurses, from the background of parental literacy, come from families where the number of children has been restricted.

[1] Three of these genealogies are reproduced in chapter eight.

TABLE 4. Analysis of recognised and named kin (dead and alive) from the genealogies of nine selected African registered nurses.

Nurse's Age; Tribal Identity; Place of Origin.	Recognised Patrilateral	Named Patrilateral	Recognised Matrilateral	Named Matrilateral	Immediate Kin Group[1]	Total Number of Kin Recognised
23; Xhosa; Umtata	56	45	19	15	11	86
24; Zulu; Greytown/ Durban	35	28	30	30	7	72
26; Zulu; Thafamasi	69	59	28	26	8	105
28; Xhosa; Matatiele	38	23	37	23	6	81
29; Xhosa; Engcobo	44	31	48	32	15	107
32; Zulu; Ladysmith District	72	38	58	35	41	171
34; Zulu; Vryheid District	32	28	19	13	18	69
35; Zulu; Umzumbe	79	53	72	40	15	166
37; Zulu; Durban	134	79	15[2]	7	5	154

It should be noted, however, that even though these informants recognised such large numbers of kin, their interaction with kinsfolk was limited to maintaining contact with their parents (if still alive), their siblings and siblings' offspring, and occasionally one or two of their parents' siblings, with whom they had had particularly close ties. Even with these immediate kin, however, personal interaction is limited, particularly where such kin do not live within commuting distance of the nurses. As may be seen from table 4, seven of these nine informants came from places other than Durban, some from

[1] Ego's immediate kin group comprises ego's parents, siblings, siblings' children and ego's own children.

[2] This particular informant's mother died two weeks after my informant was born, and her father remarried the following year. Because she was raised by her paternal grandmother and, later, her step-mother, she has had virtually no contact with her matrilateral kin and hence knows very little about them.

places hundreds of miles distant. Personal contact in these cases is, therefore, maintained by visits home during annual leave, the occasional long-weekend visit, and through correspondence.

Although interaction with kin is restricted, however, there are certain obligations to kin which nurses do not evade. In the course of my research, I did not meet a single nurse who denied or evaded her financial responsibilities to close kin, particularly for educational purposes. As students, part of these nurses' pay went to their parents to help educate younger siblings. As trained nurses, they kept their school-going siblings in pocket-money and clothes; or afforded them accommodation without charge while studying; or paid school fees for a sibling's child. The nurse's obligations to her kin were regarded as quite distinct from those of her husband to his kin, and each spouse met his or her own financial obligations to kin. These obligations fit into the nurses' framework of responsibility, discussed previously, to "educate the people", especially those who are linked to them by ties of kinship.

The second type of financial obligation never shirked by the nurses I knew, was their obligation to elderly kin, particularly parents. Once their parents reached retiring age, the nurses (in conjunction with their siblings) contributed financially to their support, or else insisted that their parents live with them (in cases where the nurses' homes were large enough to make this possible). The obligation of caring for the parents who had educated them, like the obligation to educate close kin, is assumed without question.

A further examination of the genealogies reveals some interesting social characteristics of these nurses' lineal kinsfolk. If a definition of literacy as the successful completion of at least six years of schooling[1], is accepted,

[1] For ease of comparison with the situation in certain West African countries.

it may be seen from table 5, that literacy in the second ascending generation, is virtually unknown. Over half of these nurses, however, have parents (first ascending generation) who are both literate, in terms of the above definition.

TABLE 5. Literacy among parents and grandparents of nine African nurses.

Kin Category	Literate	Semi-Literate[1]	Illiterate	Total
Father	7	2	0	9
Father's father	1	0	8	9
Father's mother	0	0	9	9
Mother	5	2	2	9
Mother's father	0	1	8	9
Mother's mother	0	0	9	9

These data may be compared with those given by White (1966:16-17). Among the group of twenty-eight student nurses he studied, eighteen fathers and nineteen mothers were literate in the sense of the above definition. It would seem, then, that between half and two-thirds of African nurses come from a background of parental literacy, but (in terms of my own data) virtually none of them have grandparents who are (or were) literate. However, the religious affiliation of members of the grandparental generation, presents an interesting pattern, as may be seen in table 6.

TABLE 6. Religious status of parents and grandparents of nine selected African registered nurses.

Kin Category	Christian[2]	Pagan
Father	9	0
Father's father	7	2
Father's mother	9*	0
Mother	9	0
Mother's father	8*	1
Mother's mother	9*	0

[1] Defined as less than six years of schooling, but has attended school.

[2] * indicates one Zionist/Shembe adherent in each category: total 3.

It would appear that there may be some connection between the high rate of affiliation to Christian churches, found among the grandparental generation (shown in table 6 above), and the high literacy rate in the parental generation (shown in table 5 above), of these particular informants. I would speculate that those persons who were sufficiently receptive to missionary influence to affiliate themselves to Christian churches, were also responsive to missionary suggestions that they should have their children educated.

However, what does emerge quite clearly from these data, is that a certain proportion of these nurses' parents, and the large majority of their grandparents, must have been of similar outlook to the people now stereotyped by African nurses, as aunties, gogo's, uncles and baba's, discussed in the previous chapter. In other words, the majority of these nine nurses' lineal kinsfolk in the first and second ascending generations, are (or were) non-elites. Some of these nurses explicitly stated that certain problems in their relationships with older kin stemmed from such lack of education. One informant (aged thirty-six) stated the position in her own family thus:

> "I enjoy spending week-ends with my 'Mum' at home, but not too often. If I was living at home all the time -- boy! We would fight most of the time! She does not like the length I wear my skirts, for instance. And she thinks I am bringing her granddaughter up very badly. And I fight with her when she is sick to go to the doctor -- she says there is nothing wrong with her and she doesn't want to bother him...No, it is good that we live apart, for this way we both live in peace, and when we do see each other, we are so glad that we can forget the differences for a little while and enjoy the company."

If this is the position in the nurse's own family of orientation, precisely the same problems exist in her affinal relationships, where the structural tensions are more obvious, and are emphasised far more by the nurses themselves. I shall return to this point later.

Given the facts that African nurses continue to recognise ties of kinship, and that there are certain tensions in their relationships with uneducated kin, especially close kin, their recognition of the obligation to help educate kinsfolk, is both logical and understandable. It would seem, from my data, that elites are not always as quick to shed the obligations of kinship as has sometimes been suggested (for example, by Lukhero, 1966). Instead, African nurses in Durban, at least, attempt to draw their own and younger generations, into their own social stratum, through education. With reference to younger kin, they are promoting not so much their own imitability, as occupational ambitions and aspirations, through their example. The example they uphold in the educational field, is shown clearly in their ambitions for their own children, and their deliberate limitation of family size in order to achieve these ambitions.

A consideration of family structure among African nurses, affords an opportunity to contrast elitist values with traditionally-oriented interests. African nurses express preference for a small family of between two and four children. This preference is put into practice by the deliberate limitation of family size, through the use of modern contraceptive techniques, particularly "the pill". An extreme example of this desire for a small family may be seen in the case of one informant who, at the age of thirty-four (having married at thirty), underwent tubal ligation immediately following the birth of her second child, by Caesarian section. As far as I know, there was no medical reason to warrant this procedure: my informant merely stated -- emphatically -- that she couldn't face the thought of having any more children! Her action conflicts not only with traditional African values, but also with the teachings of the Catholic church, of which she is an active member.

Nurses give two major reasons for desiring small families: firstly, with

a large family, maintaining their high standard of living would be virtually impossible, particularly in view of their kinship obligations discussed above. Secondly, there is the consideration of the future costs of higher education for all the children they do have. Without exception, all the nurses I spoke to on this subject, expressed the hope that their children, boys and girls, would all attend university. Some of them, while their children were still in the lower standards of primary school, had started to save, specifically, towards education costs which will only materialise in ten or more years' time[1]. The nurses' attitude is epitomised in the words of two Congress delegates:

> "We are dying for education. We need our children, the coming generation, to be educated. We do not want to say that money is the thing we need, but education, and knowledge, and all these things revolve around one thing -- money."

> "We do feel that demands are imposed on our children of leadership, study and example."

Not only do nurses express a preference for relatively small families: as may be seen from table 7, the majority of nurses actually have small families. But it should be noted that modern, effective methods of contraception, notably oral contraceptives and intra-uterine devices, have been generally available only in the last ten to twelve years, and the use of these contraceptive techniques depends on the female rather than the male.

Bearing in mind that the majority of these questionnaire respondents are still of child-bearing age, it is obvious that the figures in table 7 cannot be regarded as final indices of family size. However, it may fairly be assumed that the families of nurses in the forty to fifty age category

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[1] African nurses are thus now in the process of contributing their offspring to the ranks of the future educated elite, duplicating the tendency noted in West and East Africa, for the educated stratum of one generation to provide a significant proportion of the elites in the following generation.

are complete, and it may be seen that the median for this category is three children, while the average is 3,5. It should be remembered that these nurses, during most of their reproductive lives, did not have the use of modern contraceptives in so limiting their families.

TABLE 7. Numbers of children born to 226 African registered nurses, according to age and marital status.

Age and Marital Status of Nurse[1]	Number of Children								
	0	1	2	3	4	5	6	7	8
Under 30: single	21	4	-	-	1	-	-	-	-
Under 30: married	5	13	9	5	3	-	-	-	-
30 - 40: single	15	8	-	1	-	-	-	-	-
30 - 40: married	6	8	22	22	14	11	1	-	-
40 - 50: single	5	1	-	-	-	-	-	-	-
40 - 50: married	2	4	6	11	10	3	5	1	1
Over 50: single	-	-	-	-	-	-	-	-	-
Over 50: married	2	-	1	1	1	3	-	-	-
Total: single	41	13	-	1	1	-	-	-	-
Total: married	15	25	38	39	28	17	6	1	1
GRAND TOTAL:	56	38	38	40	29	17	6	1	1

Furthermore, if the total number of children (486) born to nurses who responded to this questionnaire, is averaged among the total number of respondents (226), the resulting figure is 2,15. If the total number of children (486) is averaged among only those nurses, regardless of marital status, who have actually born children (170), this average is still only 3,01 children per mother. Thus a small family is not only the logical corollary of African nurses' values regarding both their standard of living and their

[1] In this context, "single" indicates never married, whereas "married" includes widows and divorcees, as well as persons whose marriages are continuing.

children's education, it is also an established social fact within this particular professional group.

The fact that the use of contraceptives to limit family size, conflicts with traditional African values, has been mentioned previously. Nurses' attitudes to children and family size thus conflict with those of non-elites, including their kin. These attitudes also conflict with those of their senior affines, and constitute an extremely important aspect of the tension in nurses' relations with their in-laws: this point will be taken up in a later chapter.

Differentiation and Linkage: A Concluding Note.

In chapter four, I tried to analyse some of the ways in which nurses distinguish themselves, and are distinguished, from different sections of both the elite stratum and the general African population. In this chapter, I hope I have shown how the nurses' personal relationships with certain non-elites, such as neighbours, domestic servants and kinsfolk, link them back to the community. In one sense, these linkages cross-cut the social characteristics by which nurses identify themselves as elites. For instance, nurses' kinship obligations are a financial liability, and detract from the attainment of the potential standard of living associated with their income level. Again, I have dealt with the paradox that, while nurses live among the community at large, they cut themselves off from social interaction within this community, and withdraw into an isolationist "cult of privacy". Yet at the same time, their sense of responsibility to those less educated than themselves (and possibly the desire to flaunt their greater knowledge), leads them to involve themselves with certain non-elite members of the community. It seems that African nurses accept the fact that they are linked to some non-elites, and

instead of trying to break these links, they attempt to alter the non-elites, to fit in with their own ideas and values.

However, there is one set of ties to non-elites which nurses do not accept passively. Among nurses, affinal ties have a tendency to become eroded. Nurses reject patrivirilocal marriage, the authority of the mother-in-law role, and many traditional obligations to affines. If a nurse's husband is called upon to assist his kin, for instance, the nurse does not regard it as her obligation: her husband must see to his own kin, from his own pocket. It would seem that affinal relations are the point at which the nurse cannot afford to acknowledge non-elite ties and make the best of them. If she does submit to the authority of non-elite affines, her elite status will be endangered, for she will be expected to comply with non-elite, even anti-elite, expectations. It is with reference to marriage and its problems, to which I shall now turn, that nurses assert their elite status with greatest vigour.

CHAPTER SIX

COURTSHIP AND MARRIAGE

Probably the majority of African nurses expect to marry at some stage of their lives, for, as Kuper (1965:230) indicates: "Marriage is considered the normal relationship of adults". The late average age at which nurses do marry (26,3 years among questionnaire respondents), is partly a result of their lengthy professional training, but it would seem that, in general, nurses are in no hurry to rush into marriage once their training is completed.

> "Yes, I have a boyfriend, but we are not thinking of getting married. I will think about getting married when I am twenty-seven, twenty-eight...in five years time, perhaps. I want to further my education and travel around first." (Informant aged twenty-three.)

> "My boyfriend wants me to marry him, but I don't know... I am not ready to get married yet. I have applied to do Psychiatric Nursing. And I would love to go overseas." (Informant aged twenty-four.)

While the state of marriage is approved, however, African nurses are singularly aware of the problems that marriage may entail. A minority of nurses remain single, rather than marrying for the sake of the increased status, or prestige, that marriage itself may confer, regardless of the circumstances of the man involved.

> "Look, I would very much like to get married, but I have not met a suitable somebody yet." (Informant aged thirty.)

> "No, I am not married. Mr. Right has not turned up yet. I am still waiting for him!" (Informant aged thirty-three.)

The incidence of marriage among nurses belonging to different age

categories, may be seen in table 8.

TABLE 8. Marital status of African registered nurses according to age.

Marital Status	Under 30	30 - 40	40 - 50	Over 50	TOTAL
single	26	24	6	0	56
married	34	72	31	6*[1]	143
separated	0	2	1	1	4
divorced	0	5	6	1	12
widowed	1	5	5	0	11
Age category total:	61	108	49	8	226
Age category %age:	26,8%	47,8%	21,9%	3,5%	100%

Table 8 shows that, of the nurses who responded to the questionnaire, 42,6% of those under the age of thirty years, were single. In fact, I have reason to believe that this relatively low percentage reflects a bias in the response to this questionnaire, since many young and single nurses commented that it was "only about marriage. It doesn't concern me for I am not married". Although I explained that this was not the case, I am not sure that this explanation was always accepted. My own impression is that a majority proportion of nurses under the age of thirty, are single, even though the questionnaire response shows the reverse situation. Hence the total percentage of nurses who have never married, is probably higher than the figure of 24,8% shown in table 8. However, if one includes nurses who are separated, divorced or widowed, along with those who have never married, in the category of effectively single persons, 36,7% of nurses who responded to the questionnaire, fell into this category. Thus nearly two-fifths of these respondents were, for most practical purposes, independent of male control, and at least some of the practical problems encountered by married nurses in their everyday lives, were inapplicable to those nurses falling into the "effectively single" category.

[1] * One respondent in this category had previously been both widowed and divorced, neither of which are reflected in table 8.

Single Nurses and their "Boyfriends".

The interests and activities of married and unmarried nurses obviously differ considerably, in response to their differing duties and obligations. The married nurse has a family and home to absorb most of her free time, whereas the unmarried nurse may or may not be involved in normal family life. If she is living in the same town as her parents, the qualified, single nurse may be an important part of her family of orientation, in everyday life. But she is more likely to be working away from home, living in a nurses' residence, renting a room where she can, or staying with other unmarried nurses in a township house set aside for the use of unmarried nursing staff working at a particular hospital. Wherever she is living, however, she does not have the responsibilities of the roles of wife and mother (except in isolated cases of illegitimacy).

The single nurse is thus free to do what she likes when she is off duty, and there are no restrictions on the amount of time she can spend on social activities. She is also relatively free of financial obligations, for, although all the unmarried nurses I knew were assisting with the education of their younger siblings, such financial contributions never exceeded one-quarter of each monthly salary cheque. The single nurse, on average, probably spends much more on her own personal clothing, cosmetics and entertainment than her married colleague, on average, can afford. It is probably no exaggeration to say that, on marriage, the nurse exchanges her dress shop accounts for hire purchase agreements involving furniture. Expenditure patterns, of course, reflect both interests and obligations: among single nurses, their budgeting primarily reflects their own interests, whereas among their married colleagues, the obligations of their married roles predominate.

Most young, unmarried nurses go out, usually with their boyfriends[1], once or twice a week, to evening entertainments such as the cinema, live shows, dances or dancing classes, parties, and so on. Picnics and trips to the beach are acceptable daytime entertainment.

Initial meetings with men who are later categorised as boyfriends, occur in a variety of ways, ranging from chance encounters on shopping expeditions, to formal introductions from friends or, less frequently, kin. The initiative rests with the man to follow up the initial introduction. If his attentions are unwanted, however, the nurse has -- and has no compunction about using -- a foolproof system of excuses, based on her irregular duty hours, which enables her to avoid unwanted telephone calls and visitors.

Once established, however, the steady relationship between a nurse and her boyfriend can be maintained, if necessary, at a distance, through correspondence. I was told that many student nurses have boyfriends in their home towns, and many registered nurses have boyfriends in the towns where they trained, and whence they have since moved. Although the boyfriend status derives from a semi-permanent relationship which can be continued despite geographical separation, and although this relationship may lead to later marriage, the nurse will have little hesitation in breaking off the relationship should her boyfriend's behaviour displease her. One of my informants, for instance, had a boyfriend in his fifth year of medical studies. She had known him for over two years, but he had been regarded as her boyfriend for less than twelve months, and she was already considering breaking off the relationship, regardless of his status as an aspirant doctor.

[1] The term boyfriend is usually (though not necessarily) indicative of a sexual relationship existing on a semi-permanent basis. In view of this and other connotations of the term when it is used by Africans -- which connotations are not necessarily implied in the same term when used by Europeans -- I have used boyfriend as a "vernacular" term throughout this section, hence it is underlined. (Cf. auntie, in chapter four of this thesis.)

> "He proposed love-making to one of the midwives here at McCords, who is a friend of mine. She told him that he should be ashamed of himself, for he knew that I was her friend. She told me what had happened and I was very angry. I am still angry, because it shows that he does not respect me. If he had asked somebody else, at Kings, I would not mind so much -- somebody that I don't know. But not my own friend. We all know that men are weak, but this is very bad. How can I continue with a man who does not respect me?"

(The situation referred to had arisen only a few days previously, and my informant was obviously extremely upset about it. When I met the midwife friend -- who was the sister of one of my other informants, at a different hospital -- some months later, she also mentioned this event, and agreed entirely with her friend's action in terminating the relationship.)

Should the nurse terminate the relationship with a boyfriend, however, she has to consider the possibility of retaliatory action, which may take the form of physical assault[1], or else a more subtle plot to disturb any new attachments she may form, either by magical means, or by making her appear "cheap" in the eyes of her new boyfriend. To what extent magical means actually are used to retain or regain the favours of a nurse, I do not know, but these means are sometimes threatened. Such threats, a few of which were discussed quite spontaneously with me, were treated as a joke, or with contempt, by my informants, for African nurses overtly classify such beliefs and practices as uncivilised and superstitious. I was quite unable to find first-hand evidence of the assertion that some nurses themselves use magical practices in their love affairs. Nurses themselves say that they have better things to spend their money on, and that their salaries do not run to useless expenditure on muti. I am inclined to think that, with possible individual

[1] In February this year (1971), a staff nurse was murdered while on duty in the casualty theatre of King Edward VIII Hospital, by a man whom she had recently refused to continue meeting as her boyfriend. The man, a well-known soccer player, was sentenced to twelve years' imprisonment. This case attracted widespread publicity in both African and European press releases. It was, of course, an extreme case of the point in question, and less extreme cases occur more frequently. (See Weekend World, Sunday 28 March 1971.)

exceptions, this is a reflection of their true feelings on the subject and that, in general, assertions that nurses do visit inyanga's and use magical herbs and potions, are possibly a reflection of envy and an attempt to discredit the image of the nurse.

Where the boyfriend relationship does involve sexual relations, as it very frequently does, the nurse is in a position that few African women are, for she not only knows which modern contraceptive techniques are most efficient, but also has relatively easy access to the method of her choice[1]. In large provincial hospitals, it seems that supplies of oral contraceptives are made available to the nursing staff, albeit by devious routes. It is also possible to have an intra-uterine device (I.U.D.) inserted. In smaller mission hospitals, where greater emphasis is laid on Christian morality, private practitioners outside the hospital may be willing to prescribe the "pill" or insert a loop or administer an injection of depo-progestogens, the dosage being absorbed slowly over a period of months. Whatever the method used, however, the important point is that a nurse will not expose herself, in normal circumstances, to the risk of an unwanted, illegitimate pregnancy, and she takes active precautionary steps against this possibility, rather than relying on her boyfriend's discretion. Bearing an illegitimate child carries the stigma of disgrace for an African nurse, both on account of her Christian upbringing, and her elite status. Illegitimate pregnancy during the training years may cost a student nurse her career, and such an occurrence is as much a disgrace to her parents as to the nurse herself.

> "Well, I know that some nurses try and trap a man into marrying them by falling pregnant -- especially the medical

[1] The use of contraceptives, and the desire for a small family (see chapter five, pages 103-106) are, perhaps, indications of a more "modern" attitude on the part of African nurses in South Africa, than that found among educated women in West African countries. Caldwell (1965) and Little (1966), for instance, report minimal inclination towards the deliberate limitation of family size through the use of modern contraceptives, among potential elites (students) in Ghana and Sierra Leone respectively.

> students. But I think that is stupid, because it never works. Either he will refuse to marry you, and there you are, left with the children, being a burden and a disgrace to your parents. Or else he will marry you because he has to[1], and play around with other women, and not come home, and it will end up in a divorce. Well, I don't know what the other nurses think, but I do know that Tandi (her room-mate) agrees with me on this point: neither of us would like to have an illegitimate child."

It would appear, however, from the questionnaire returns, that a significant proportion of unmarried nurses <u>do</u> have illegitimate children, since fifteen, of a total of fifty-six single nurses, were mothers. It is not unlikely that the majority of these illegitimate children were born during the nurses' student years, since it is possible, in some hospitals, to recommence training after bearing an illegitimate child, and thus to qualify. I have personal knowledge of only one case in which an unmarried nurse had a child <u>after</u> she had qualified. This nurse (a Catholic) has three illegitimate children and, in this respect and many others, is exceptional among African nurses.

Despite a fairly high proportion of unmarried mothers among single nurses, however, the overall legitimacy rate[2] calculated from the questionnaire returns, was extremely low, being a mere 4,1%. This figure would appear to indicate that, although a fairly high number of nurses do have illegitimate children, very few indeed have more than one illegitimate child. Bearing illegitimate children is not in keeping with the nurse's social position, for she is not only educated, and a Christian, she is also a "professional

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[1] Until fairly recently, a medical student at the University of Natal had to marry a girl he had impregnated, or else leave the Medical School.

[2] Calculated as $\frac{\text{number of illegitimate children}}{\text{total number of children}} \times 100: \frac{20}{486} \times 100 = 4,1\%$

It should be noted that this is a minimum figure, since the questionnaire could not show up illegitimate children born <u>before</u> marriage, where the respondent was married. I know that some nurses, now married, have born illegitimate children, but this fact is not reflected in the figure of 4,1% given above. However, were such children to be included, I doubt very much that the total would rise above 8%.

somebody", a member of the modern elite, for whom such behaviour is undesirable and disapproved, and leads to loss of status or prestige. The elites are expected to bear their children within the framework of marriage.

Expectations of Marriage.

> "We nurses, or rather, we girls, have the bad habit of marrying men, or going out with them, because of their money, or their social position. But then, they also do this. A nurse is a 'good catch'!"

The nurse expects her boyfriend to dress well, to take her to places she wishes to visit, and to behave in a "civilised way". In addition to these expectations, however, the criteria of romantic love and respectability guide her choice of a husband.

The concept of romantic love is not easy to define, but as the African nurse sees it, love involves a man in primary responsibility to his wife, the woman he loves. He must, therefore, be prepared to put his wife's wishes before those of his parents and other kin, even where she will require him to break with tradition and custom, and even to go directly against the wishes and expectations of his kin. Love binds two individuals, a man and his wife, in a relationship from which others are barred:

> "I am hoping that all of the lobola business will be finished before the wedding day, otherwise there will be trouble. Always there is trouble with the lobola, and I don't want anything to spoil the wedding. After all, it is our day, his and mine, not theirs."

Any man who does not measure up to the nurse's expectations of the elusive notion of romantic love, is not regarded as marriageable.

> "B____ waited for eight years for me to change my mind and

> marry him. He is a very wealthy businessman. He is also a divorcé and so, because of my religion, I couldn't marry him anyway. But I never loved him. It is funny. He is a good man, a very fine person, but for me he is just a good friend. I could never have married a man I did not love... And as for E____ (her husband) nobody in my family understands why I married <u>him</u>! He is dark. He doesn't have money. <u>But</u> he is the one in whom there are the most qualities <u>I</u> wanted -- and I cannot tell you what precisely those qualities are, so do not ask me about that!"

While love is not easily analysed, however, the components of respectability are more readily identified. Firstly, the respectable man does not drink immoderately. Indeed, since the nurse is only too familiar with the problems attendant upon the excessive consumption of alcohol, the man she marries would ideally not drink at all. Most important of all, money must not be spent on drink at the expense of a high standard of living. Then too, education is an index of respectability, as is work stability, good taste in dress, modern recreational interests, and so on. A respectable person also claims affiliation to one of the orthodox Christian churches, whether or not he attends church regularly.

According to my informants, it would seem that many men "play up" to these expectations while courting a nurse, only to drop the pretence once the wedding has taken place. Because of her high salary and regular income, relative to most of the African population, a nurse is a decided asset, as a wife, to the man who is involved in a highly competitive labour market situation, as the non-professional African man is.

Bearing the above expectations in mind, it behoves a nurse to choose her husband carefully. There is, however, a dearth of suitably qualified African men from whom the nurse can choose. As I have shown previously, in chapter three, registered nurses alone probably outnumber the entire male professional and semi-professional elite, and many nurses, if they wish to

marry at all, must, therefore, marry non-elite men. I shall discuss in some detail the educational qualifications and occupations of nurses' husbands, in the next chapter, but it is necessary to mention here that, in terms of school education alone, 75% of African nurses' husbands have had the same or more schooling than their wives. Thus it becomes apparent that the quantity of education each category (nurses, and their husbands) has, is less significant than the quality of such education. The nursing training, for instance, is not merely a specialised technical training which instils knowledge and skills specific to the occupation of nursing, into those who undergo this training. It is also a very important socialisation process, initiating African students, in particular, into an ethos and a way of life that has arisen in and is peculiar to, industrialised and technologically developed societies. Because very few African men undergo a similar socialisation process, they do not share the same values and beliefs to the same extent as do the nurses, and they are thus regarded as being "less educated".

Despite African nurses' awareness of the difficulties entailed in marriage, however, the majority of them are, or have been married. This may be, as one informant told me, because at a certain stage in their lives, "they feel the need to marry". In view of the sexual referent in the boyfriend relationship, this "need" is unlikely to be sexual, but whether it is the result of cultural expectations, status expectations, or simply a desire to have (legitimate) children, is impossible to tell. Probably all three of these factors are involved.

Marriage Negotiations.

In Africa, it is a truism that marriage not only involves two

individuals, but also the kin groups of these individuals. As far as African nurses are concerned, however, this commonplace has important implications for highlighting their elite status. In the processes involved in contracting a marriage, the expectations and influence of non-elites on their elite kin, may be seen very clearly, for marriage is the field in which elements of African tradition and custom impinge most noticeably on the lives of African nurses. Yet, in this situation, the nurses' elite status is demonstrated more clearly, probably, than in any other aspect of their lives.

Once a nurse has accepted a proposal of marriage, usually from a boyfriend, negotiations are set in motion. The nurse will inform her mother that she is expecting visitors on a particular day, and her mother will relay this news of an impending suitor to the nurse's father, or guardian. Although, ideally, the girl should be at home when her suitor and his companions arrive, very often the nurse travels home with them, because of her restricted off-duty hours. She must be there, however, even though she is barred from the negotiations until agreement has been reached, and she is required to state her willingness to marry this particular man. Although the suitor takes with him the umkhongi, or traditional "go-between", and although he usually leaves the negotiations in the hands of this man (who may be a kinsman, or an unrelated friend), the girl's father or guardian is more interested in seeing the suitor himself, and assessing this man's suitability to marry his highly-educated daughter or ward. In provinces other than Natal, the father's or guardian's consent to the marriage is largely a formality, because if the nurse really wishes to marry her suitor, she can do so without even consulting her kin, as a small minority of nurses have done. In the other provinces, African women may marry by civil rites. However, for a marriage to be recognised under the Common Law in Natal, it must be performed by a priest who is a recognised marriage officer. Hence, in Natal, where the bride

requires her father or guardian to "give her away" in a religious ceremony, the agreement outlined above is necessary.

Once the lobola negotiations have been concluded, the nurse's family, including herself, and the negotiating party, usually sit down to a meal together. Although a goat or other animal may be slaughtered for this meal, this appears to happen only in roughly fifty percent of cases, although I do not have evidence from sufficient cases to quote this as an entirely reliable figure. Whether or not a beast is slaughtered seems to depend on the financial standing of the nurse's kin, and possibly on her guardian's age and educational background as well.

Lobola[1].

Attitudes towards the payment of lobola vary among African nurses. Some (mostly over thirty years of age) wholeheartedly support the principle that a man should express his love for his wife-to-be in tangible form, that he should "pay" for the privilege of acquiring a wife. Others are of the opinion that it should be the woman's decision whether lobola should be paid for her or not, and to whom it should go. (This attitude is an interesting assertion of status, and obviously conflicts with traditional ideas regarding the proper role of women in society!) Still others, mainly in the younger generation of unmarried nurses, feel very strongly that the custom should be abolished completely, because of its crippling financial effects on the newly-married couple. Money should not be spent on lobola payments at the expense of the anticipated high standard of living, according to these nurses, because such high lobola lands the married couple in debt for furniture and other necessities of life, and this, in turn, causes other problems. A high lobola payment may thus be regarded as one of the reasons why nurses do not

[1] Cf. Brandel, 1958, passim.

get married early; and because of the financial aspect, a high lobola payment may also be regarded as one of the reasons why marriages stand a good chance of failing, by African nurses who disapprove of the lobola custom. The difference between this attitude towards lobola, and that of the "average African", needs no emphasis, but is indicative of the cleavage in attitudes and values between elites and non-elites[1].

One aspect of lobola to which all African nurses object, however, regardless of their other opinions about it, is the tendency for "uneducated" husbands to remind their wives that they were "bought"[2]. Such a claim tends to occur in the heat of domestic quarrels, and all nurses resent such an attempt to assert authority and demand obedience.

Weighing against these negative considerations, however, is the "fact" (as nurses see it) that the payment of lobola solemnises a marriage in the eyes of African men, "even educated African men". Nurses are explicit about the polygynous nature, as they see it, of African men, and they are well aware that a man will have little compunction about deserting a wife for whom he did not pay lobola. This belief that lobola has a stabilising effect on marriage, would appear to be supported by questionnaire data, for of the fifteen nurses for whom lobola was not paid, five are either separated or divorced. Using the phi co-efficient, a correlation of -0,2429 reflects a low, but significant, negative correlation between the payment of lobola and the dissolution of marriage.

In any case, it would appear that the nurses' attitudes are really of little relevance, as yet, in determining whether lobola is actually paid, or

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[1] Even though a similar range of opinion regarding lobola might be found among women in the general (African) population, I think that the proportion of nurses holding negative opinions is probably considerably larger than would be found among other sections of the population.

[2] This English term is used by nurses themselves, and is not a translation of a vernacular usage.

not. Table 9 shows that lobola was paid in the vast majority of marriages, according to questionnaire returns.

TABLE 9. Lobola payments according to age category for African nurses.

Lobola Amount	Under 30	30 - 40	40 - 50	Over 50	Total
not given	1	6	3	5	15
unknown	2	2	-	-	4
< 11 cattle	1	4	-	-	5
11 cattle	3	9	4	-	16
> 11 cattle	1	3	4	-	8
< R100	1	1	3	-	5
R100 - R199	3	12	11	-	26
R200 - R299	4	30	16	2	52
R300 - R399	7	9	-	-	16
R400 +	13	9	2	1	25
TOTAL:	36	85	43	8	172[1]
Total number of marriages continuing:	34	72	31	6	143

From table 9, it may be seen that there is a definite trend towards high cash lobola payments for nurses in the under thirty age category, and this trend is possibly the source from which disapproval of lobola, on financial grounds, derives. At the same time, however, table 9 also indicates that lobola has been given, almost without exception, in the youngest age category, whereas in the oldest age group, lobola was not given in 62,5% of cases -- possibly because of missionary disapproval. The trend towards high cash payments may be an indication of the necessity for a high lobola payment today, if only to cover the expenses involved in the elite weddings demanded by African nurses. The total cost of the wedding may be as high as R1000, and few cost less than R250. The modern trend towards high lobola payments may also reflect the status differential between nurses and a high proportion of their non-elite husbands: these payments may, perhaps,

[1] One respondent had contracted a total of three marriages.

represent "status purchase" on the part of non-elite men, though I do not wish to over-emphasise this possibility.

Lobola payments must be completed before the date of the wedding is finalised. The final completion of payment usually takes the suitor between three and six months, and the period between reaching agreement regarding the amount of lobola (when half of the amount is handed over, usually) and the final completion of payment, marks the official engagement. According to Brandel (1958) and Kuper (1965), the nurse herself may assist her fiancé with the payment of the lobola, but I did not find any instances of such assistance among my own informants, although some of them believed that it did happen occasionally. Although the wedding is deferred until payments have been completed, however, the engagement is made known as soon as the negotiations have been concluded satisfactorily.

The Engagement Party.

On the day following the lobola negotiations, the nurse and her fiancé, along with kin and friends, usually have their engagement ring blessed at a special church ceremony, by a priest. An address on the subject of betrothal is given during this service. Afterwards, a party is held, usually in the local school hall, for friends and kin. Soft drinks and light refreshments are served to the guests, followed by speeches and (ballroom) dancing.

The innovative and standard-setting functions of elites are seen very clearly in the institution of the engagement party, with its cakes and sandwiches, formal speeches and modern ballroom dancing, which follow on the formal blessing of the engagement ring. Thus, one of my informants[1], whose

[1] See chapter eight, "Mary-Jane".

natal home was on a farm in the Ladysmith district, was the first person in her family to have had such an engagement party: she is the seventh child. Her engagement party was the first in the district, and she is very proud of this fact, since the many people who attended it regarded her as being very modern and progressive. She herself feels that her prestige, both personally, and as a nurse, was enhanced by this event, which she had learned about during her nursing training at the McCord Zulu Hospital. That was in 1961. Today, ten years later, such engagement parties are quite common, even among non-professionals, and the example of the nurses, in earlier years, may be presumed to have been partly responsible for the wider diffusion of this practice.

The Kitchen Party.

While engagement parties are fairly common today, the kitchen party is not. The institution of the kitchen party appears to have originated, among African nurses, at the McCord Zulu Hospital, for awareness of this practice, among older nurses, appears to be restricted to those nurses who trained at McCord's. Most of the younger generation of nurses know about the kitchen party, but as far as I am aware, it is unknown among other sections of the African population.

The kitchen party is dependent upon the engaged nurse issuing a general wedding invitation to the entire nursing and medical staff of the hospital at which she works. If she issues such an invitation, a party will be arranged for her, either by her student group (if she is still a student), or else by her close friends, if she is trained. Although her close friends usually are her bridesmaids, the organisation of the kitchen party is not regarded as the responsibility solely of the bridesmaids.

Invitations to the kitchen party are issued, and a list of gifts for the kitchen is compiled. Each invited guest undertakes to provide one (or more) of the listed items, thus duplication of gifts is avoided. The proceedings are (supposed to be) kept secret from the central figure. Each guest brings, in addition to her gift, a plate of food, and the organisers provide tea. The party is usually held in the nurses' home, but always somewhere within the hospital precincts. The bride-to-be is taken by surprise (or is supposed to be), and there is much teasing and laughter as she unwraps all the gifts. When she is finished, tea and cakes are served. Later, she will write individual notes of thanks to those who presented her with gifts.

Should the bride-to-be omit to issue a general invitation to her wedding, however, her nursing colleagues feel themselves under no obligation to supply her with kitchen-ware. All attempts to organise a kitchen party after a small, private wedding, are doomed to failure. The element of reciprocity in this situation is marked. But contributing a gift at a kitchen party does not mean that the invitee is absolved from presenting a wedding gift.

The kitchen party is arranged on the basis of friendly relationships in the working situation, and involves hospital friends and colleagues, rather than non-nursing kin. As yet the custom appears to be restricted to African nurses, and is a further indication of their innovative role in African society.

Wedding Celebrations: Legal, Religious and Traditional Aspects.

The legal, religious and traditional aspects of marriage are clearly distinguishable in the weddings of African nurses, being separated from one

another by both time and distance.

If the marriage is to be valid and recognised under Roman-Dutch (Common) Law, an African woman and her prospective husband, in Natal, must register their intent to marry, in advance of the actual wedding, with the marriage registering authority in the woman's magisterial district[1]. Such registration involves the decision to marry in or out of community of property, and it would seem that the majority of African nurses marry out of community of property[2], which means that they are not subject to the authority of the husband's kin in the event of his death.

This registration requirement in Natal, which must be fulfilled before the marriage can be solemnised in a church ceremony, involves both parties to the marriage in a certain amount of inconvenience, since both must be present for the registration, and the registering offices are open only during normal office hours. It happens, on occasion, that the church ceremony has to be postponed because of difficulties involved in registering the marriage. This is, of course, most inconvenient when the printed wedding invitations (in English) have already been distributed, and all the other wedding arrangements concluded. Thus it usually happens that the wedding arrangements are not finally settled until the marriage has been registered, and this conveys the impression that the wedding has been organised very hastily indeed, though in fact, the plans will have been made months before.

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[1] A detailed account of the legal requirements for Africans contracting monogamous, common-law marriages in the four different provinces of South Africa, has been given by H. J. Simons, in his work concerning African women, but since he is a banned person, I cannot utilise his material.
Seedat (1969:99) deals specifically with this legal requirement of registration in Natal.

[2] See Seedat (1969:108 ff.) for a discussion of the implications of marriage in and out of community of property, as far as Africans are concerned.

After the registration, the couple are legally free to marry in church, and the vast majority of African nurses have large "white weddings", with as many as eight bridesmaids, plus groomsmen, flower girls and page boys, with the groom and his attendants in top hats and tails -- although at smaller weddings the male contingent may sometimes wear suits. This is the "society wedding" par excellence, and such weddings often receive detailed press coverage.

The church ceremony is followed by the European type of reception, at which tea and drinks, cakes and sandwiches are served to the guests; formal speeches are followed by the cutting of the multi-tiered wedding cake; and the bridal waltz precedes general dancing. This reception caters for the educated friends of the bridal couple, and European guests. Even though less educated kinsfolk may attend, the tone of the church ceremony and reception is very strictly western. As mentioned previously, the total cost of such celebrations varies between R250 and R1000, some of which is covered by the lobola, some by the nurse herself from her savings, and certain items (for example, photographs[1]) are the financial responsibility of the groom, particularly if lobola has not been paid.

Despite the importance of the "white wedding" or "church wedding" to the nurse herself (as evidenced by the effort and expense which go into organising it), there are few African weddings, even of nurses, that do not cater for the traditionally-oriented interests of the older generation of kin. The traditional celebratory slaughter of an ox at the groom's home may be delayed for as much as four years after the wedding has been solemnised in church, but it will usually be held eventually. However, traditional or

[1] Wedding albums are among the nurses' most prized possessions, and not being able to afford a photographer to cover the wedding is regarded as a social disgrace. Since I was unable to attend either of the two weddings that occurred among my informants during the course of my fieldwork -- since I did not have the necessary rural permits -- these albums were invaluable sources of information.

PLATE VI.

(a) Durban, 1961: at the Botanic Gardens, a young staff nurse assumes a typical pose for the wedding photographer.

(b) Mother and child: a staff nurse and her first-born son, aged six months.

customary celebrations at the bride's natal home[1] would appear to be more important (judging from informants' accounts) than those held at the groom's home. At the bride's home, the most important feature is the parade around the homestead by the bride and her attendants, dressed in their wedding finery. After this parade, the older women lecture the bride on her future duties and responsibilities as wife, daughter-in-law and mother. And as one informant said ruefully, "And how they lecture! Oh my!" Then the singing and dancing commences, along traditional lines, and the bride is required to show willing, by at least a few shuffling steps, to participate in this dancing. Formerly she would have danced solo, in her bridal beadwork: today the nurse uses her long white wedding gown as an excuse to retire early from this dancing, and not to do the traditional steps.

Feasting is the inevitable accompaniment of singing and dancing. At least one ox, usually two or three, plus a couple of sheep and numerous chickens, will have been slaughtered the previous evening, and the meat cooked by the bride's mother and other female kin. Served with stiff mealie porridge, rice and green relishes, the meat is washed down with brewed beer and soft drinks bought in town. Not only kin attend these traditional celebrations. Anyone is welcome to attend, and they come from far and wide, bringing food and gifts, usually small sums of money, for the bride.

When the feasting and dancing is nearly over, the bride and groom change into their "going away" clothes. The bride usually chooses a smartly-cut suit, with hat and gloves, expensive handbag and matching shoes, while the groom dresses in a conservative suit. Before the celebrations finally come to an end, they retire.

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[1] It is worthy of note that this type of customary celebration at the bride's home, may take place immediately before or (more usually) immediately after, the church wedding and formal reception.

While this type of traditional celebration is always held at the bride's home, close in time to the church wedding, the celebrations at the groom's home may be delayed; or cut down merely to a celebratory communal meal involving the bridal couple and the groom's parents; or even omitted completely. It would seem that the traditional celebrations at the groom's home fall into the "necessary evil" category as far as the nurse herself is concerned, and this is probably because of her outright rejection of patrivirilocal marriage and the authority of her mother-in-law. The majority of African nurses are not prepared to assume the role of umakoti.

> "I will not live with my husband's people. I don't care that it is the custom. I don't believe that it is good to live with your in-laws, and I won't. And if it causes trouble -- well, that is just too bad!"

> "No. It is never good. I would never live with my husband's parents. For some reason they don't seem to like us, especially if we don't settle down to live with them and listen to them in everything...Look at my in-laws. They think that there is something wrong with me because we have been married two years now, and have no children. They do not understand at all about family planning, so I cannot begin to explain to them."

And the obverse of this attitude is displayed by one informant, aged forty-one, who applauded her mother-in-law's refusal to stay with her only son and his family, because she felt such an arrangement would impose unnecessary strains on their family relationships:

> "She is very civilised -- the best mother-in-law in the whole world! No, I mean it -- the very best!"

The confliot situation involving a quite highly educated professional nurse and an uneducated elderly woman, in the roles of daughter-in-law and mother-in-law respectively, should not be minimised, especially in view of the traditional Nguni expectations of the umakoti. African nurses are not

prepared to submit themselves to the authority of older women whose knowledge is less than their own, whose ideas and beliefs are traditionally-oriented, particularly regarding matters of hygiene, diet and illness, and whose style of living differs radically from their own: hence their vehement rejection of patrivirilocal marriage. They do not expect to alter the ways of the older generation, but they do demand that their own lives be lived independently.

And insofar as the nurses succeed in their stand against the ideas of the older generation, and are able to reject patrivirilocal marriage, to establish (or persuade their husbands to establish) nuclear households, to limit the number of children they have and bring them up in accordance with their own ideas -- inasmuch as they achieve autonomy from the older generation, they do divide the African community, and set new precedents and different standards, which conflict with the old ones.

Thus it may be seen that, in their attitudes to and expectations of marriage, as well as in the actual details of wedding ceremonies, nurses do belong to the modern elite stratum of African society. And for the very reason that their conflicts with their non-elite kin are emphasised within the whole structure of marriage and its ensuing expectations and obligations, the elite status of the nurses is most apparent in this field. Nevertheless, while the nurses would appear to have won their battle against non-elite ideas regarding marriage, the new marriage situation that they have been responsible for creating for themselves, is not without certain significant problems, which, while these are not confined to nurses' marriages, are the result of their elite expectations.

CHAPTER SEVEN

MARITAL PROBLEMS AND THE DISSOLUTION OF MARRIAGE

As a "professional somebody", the nurse expects to continue practising her profession after marriage. It may indeed be a "privilege to be employed"[1] for a nurse, especially in a community where unemployment is rife, but it is also a right that has been earned by the successful completion of a long period of training for a particular occupation. Not only is the nurse's contribution to family finances a significant reason why she should continue to work after marriage, but her interests lie in the stimulating working environment, rather than in the mundane affairs of the home. One of my informants, for instance, cut short her six months' maternity leave, because she found domestic matters and her first-born "screaming brat" far less interesting than her job. Obviously, then, the married nurse faces the problems associated with being a working wife and mother.

Domestic Life and Conjugal Roles.

Once married, the nurse's domestic roles of wife, housekeeper and mother, are complicated by her hours of work as well as her absence from home. The African registered nurse works a five-and-one-half-day week, with split day shifts. Starting work at either 7.00 or 7.30 am, the earliest she will finish will be 1.30 or 2.00 pm, on her half-day off. If she is working a straight eight-hour shift, she will be free at 4.00 pm, but if she has three or four hours off during the day, she will be on duty until 7.00 or 7.30 pm. The very latest she can arise in the morning is 6.00 am, and if she lives far from her place of work, she may have to rise as early as 4.00 am.

[1] This phrase was used by a delegate to the 1970 Congress.

If she works until after 7.00 pm, she can expect to arrive home sometime between 8.00 and 9.30 pm. Many African nurses in the Durban area live fifteen miles and more from the hospitals at which they work. If they do not own private transport, and, therefore, depend on the public transport system, they may spend up to four hours per day travelling. The public transport system is not only unreliable, it may also be downright unsafe, since African nurses are widely reputed to earn good salaries and are, therefore, obvious targets for the armed thief. But travelling on buses and trains is also uncomfortable, and distasteful to the nurse because of the crowded conditions. It is not surprising, then, that the avowed ambition of African nurses, married and single, is to own a reliable car.

One obvious consequence of the hours that she spends travelling and working, is that the nurse has very little time to devote to her home and family. But it remains her responsibility to see that her domestic duties are fulfilled satisfactorily, and this entails employing a domestic servant[1]. The servant is the nurse's financial liability, since she undertakes the domestic duties that the nurse, as wife and mother, should be doing herself. If the servant is a young teenager, the nurse will pay her between R6.00 and R8.00 per month. If she is a mature woman, she will get an average wage of R10.00 per month. Such wages amount to pocket money, since the servant lives with the family and shares their food.

The effects on the children, of the working nurse's absence from home, are regarded as being dependent upon the quality of the domestic servant. If the maid follows the nurse's instructions in the matters of discipline and feeding, then the nurse may regard her own absence as being at least partly beneficial, in that the children appreciate her presence far more on the

[1] See chapter five.

occasions when she is home, than they would if she was there all the time. But if the maid cannot be trusted to keep the children off the street, see that they are fed properly (particularly infants on formula milk feeds), and otherwise neglects her duties in favour of visiting around the neighbourhood and entertaining undesirable (non-elite) friends in the nurse's own home, then the nurse worries about the effects her absence may have on her children's development. The nurse's biggest fear is that her maid will neglect the proper feeding of her infant, for to have her own child admitted to hospital suffering from a nutritional disorder, is the greatest disgrace any African nurse can imagine befalling her.

In exchanging her domestic duties for economic function, the married nurse has largely relinquished the duties that, in traditional society, comprise the role of wife. As a trained nurse, she expects and is expected to work and contribute to the family income, especially if she is to be able to live in accordance with her own expectations and desired standard of living. Hence her role as an elite wife is predominantly, even primarily, economic. And even though her children may be more neglected in terms of parental time devoted to them, than some of their age-mates of non-working mothers, and most European children, they do have greater material advantages than most other children in the African population: they live in well-furnished homes, wear good clothes, eat nutritious food, and are assured of the best education available. All of these advantages, of course, hinge on the family's relative financial well-being.

Financial Arrangements in the Home.

When the wife is contributing approximately half of the total household income, this obviously has important effects on marital

relationships and the balance of authority within the home. The nurse is not financially dependent upon her husband, and this fact results in husband-wife relationships rather different from those expected, traditionally, in African society. The egalitarian behaviour patterns of husbands and wives among the elites, are seen in the situation where the entire family eats together, where husband and wife share their leisure activities, including playing with the children and supervising their school work, and where the husband frequently undertakes the chore of marketing for the family's needs. Thus the saying "Marry a nurse and you've hit the jackpot!" (which is idiomatic in the African community), is merely one side of the coin, and it takes little account of the behavioural re-orientations involved in such a marriage.

As far as domestic budgeting is concerned, most African nurses appear to be involved in one of two situations. In the first, financial policy is determined jointly by husband and wife, each of whom assumes responsibility for certain standard items of expenditure, while all surplus money is pooled in a joint savings account (a bank or building society account, not a Post Office Savings Account, which is regarded as suitable only for uneducated labourers). In this situation, each spouse knows the exact income of the other, all financial affairs are considered to be their joint responsibility and interest, and all decisions on capital expenditure, from their joint savings account, are taken together. Usually the husband assumes responsibility for the rent, electricity, and all food bills, plus school fees and books, and running expenses on the car when one is owned. The nurse furnishes the house, clothes the family, pays the maid, and meets day-to-day expenditure on food items.

Alternatively, the nurse and her husband may follow the second pattern of household budgeting, in which financial responsibilities are allocated as

above, but neither partner knows the precise details of the other's income or expenditure. It would appear that the more popular form of family budgeting is the first, but a number of nurses prefer the second pattern.

In addition to these two types of budgeting, there is a third, which only one of my informants followed. Her husband had handed over to her complete responsibility for the family's financial affairs. Each week he gave her his total pay-packet, and accepted from her a stipulated sum for his own personal use. This particular couple had found that the husband had tended to mismanage his responsibilities while they had followed the first pattern of budgeting, described above, and the ensuing quarrel resulted in his handing over to his wife complete responsibility for banking and everything else. While she was in complete control, he could not be held responsible for any shortages! To what extent this latter type of household budgeting may be more widely practised, I do not know. Nurses are extremely reticent about their financial affairs, and the delicate issue of income and expenditure details jeopardised my relationship with at least one of my regular informants and affected the progress of my research at the hospital at which she worked[1].

As far as I could ascertain, there appear to be no correlations between these different patterns of household budgeting, and the educational standards or occupations of the nurses' husbands, but the data that I have are not statistically significant. It would appear, though, that the nurses' pre-marital savings patterns and use of banking facilities do influence financial arrangements, as would be expected. All of the different budgeting patterns demonstrate the influence of the nurse-wife in the family's financial affairs. She is not expected to take what she is given without

[1] At the 1970 Congress, immediately prior to the discussion on salaries, a delegate requested that the reporters present should treat the proceedings as confidential: nurses do not wish the African public to know exactly how much they earn.

question, and make it stretch to cover all requirements: rather, she may be regarded as co-director of family and household affairs. Financial management is yet another instance of the difference between the traditional pattern of male authority and female obedience, and the egalitarian relationship which exists between nurses and their husbands.

The Ideology of Independence among African Nurses.

Because of her professional status, the African nurse is expected, and herself expects to be "independent". Not only financial independence is involved in this idea, but what one might term an "ideology of independence", which is reflected in the attenuation of interaction with kin in favour of a few, carefully selected friendships, the emphasis on a nuclear family structure, and rejection of the traditional authority role of affines. But this independent attitude goes still further, and affects the husband-wife relationship as well: one example of the nurses' independence has been seen above, in the discussion of financial arrangements between nurses and their husbands.

Perhaps one of the reasons for the nurses' independent attitude, lies in their belief that African men, in general,

> "...are not yet as far up as the nurses. They are not so well educated. This conflict that our generation has, we hope it will not affect our children, because they will have been brought up in a civilised way...Let us look into the future. Say that, in twenty years' time, N____ (her daughter) would marry M____ (her staff nurse neighbour's son). She will not have the problems that I have, because she will marry a man who has been brought up in the same way, to appreciate the same things. So you see, I am fighting to bring L____ and N____ up as 'spoilt Bantu'...!! I grew up in a mud hut in the country, but I am absolutely determined that they will be brought up decently."

In terms of school education alone, however, the nurses' belief that African men, including their husbands, are less well educated than themselves, is somewhat inaccurate, as table 10 shows.

TABLE 10. Educational qualifications of African nurses and their husbands.

Educational Standard	Nurses	Nurses' Husbands
post-matriculation (university or other training)	2	28
teaching qualification	22[1]	24
matriculation	39	37
form IV	6	5
junior certificate/form III/ standard 9	143	47
form II/standard 8	13	11
form I/standard 7	1	7
standard 6 or lower	-	10
unknown	-	1
TOTAL:[2]	226	170

Furthermore, questionnaire results show that eighty-one (81) husbands hold higher educational qualifications than their wives, while forty-six (46) have attained the same educational level as their wives. Only 24,7% (42 of 170) have had less schooling than their wives. But as I have mentioned previously, the quality of education differs between the two groups. As a result of their nursing training, the nurses are firmly committed to a system of values based on those of the West, whereas their "less educated"[3] husbands are not. And it is this situation, as the nurses see it, that gives rise to the problems they experience in marriage, since their own expectations differ from those of their husbands. To live in a house that has no running water; to brew beer in accordance with the traditional role of wife; to

[1] Acquired before commencing nursing training.

[2] The educational status of all questionnaire respondents is given, regardless of their marital status, hence the discrepancy in totals for the two groups.

[3] In this context, "less educated" could be regarded, perhaps more accurately, as "less westernised".

slaughter for the ancestors; to insist on having sons in the family -- none of these ideas finds ready acceptance among nurses, but their husbands may well expect such behaviour. The nurse may, then, be involved in a conflict of ideas, values and behaviour with her husband, and because of her earning power, can afford to follow her own inclinations. The (cultural) conflict of values, plus her financial security, enables the nurse to emphasise the fact that she can, and if necessary, will "go it alone". Her independent attitude is quite evident.

African nurses regard themselves, and would appear to be regarded by most African men, as "westernised" to the point of being "Black Europeans": they may actually be called this as a form of abuse by African men. The material technology of "western" culture is regarded, by nurses, as essential for decent living, but it may be regarded as ostentatious and unnecessary luxury by African men in the non-elite category. This is probably the reason why the nurse assumes financial responsibility for furnishing the house and clothing the family: she can pay for what she demands, while the man concerns himself with the essentials of rent, food[1] and transport. Obviously, the above generalisation applies primarily -- but not solely -- to the less well educated of the nurses' husbands, and by no means to all of them. However, there is often conflict between husband and wife over their respective assessments of what constitutes the minimum basis for decent living.

Given, then, the situation of conflicting values, the feeling of generalised superiority over men on the part of nurses, and their financial

[1] In this respect, it is worth noting that the task of feeding the family, in normal circumstances, falls to the woman in traditional society, since she is responsible for the cultivation of the staple crops. Hence the allocation of financial responsibilities found among African nurses and their husbands, as members of the elite stratum, reverses the accepted pattern found among traditionalists: I am indebted to Mrs. Harriett Sibisi for drawing this distinction to my attention.

security, it is hardly surprising to find what I have termed the ideology of independence among them. If the nurse feels so inclined, she can literally tell her husband to "go to hell", and mean it. Or she can make his life so unpleasant that he will leave her. For part of this ideology of independence involves the idea that a husband is an expendable luxury, and if he causes the nurse more trouble than he is worth, there is no point in continuing the marriage. Any African nurse, regardless of age or marital status, will assert that nurses' marriages do not last, and that there is a higher rate of marital break-up among nurses than is found in any other section of the African community -- because nurses are independent, and do not stand for nonsense on the part of their husbands. The supposed high rate of marital break-up is indeed one reason given by single nurses to explain why they are in no hurry to get married.

The difficulties nurses experience with their husbands are usually concerned with two major problems: alcohol and women. Although it is deprecated as leading to "uncivilised" behaviour, drinking in itself is considered to be (barely) tolerable. But what is not tolerated is the physical assault that often results from the excessive consumption of alcohol. A drunken husband is quite likely to beat his wife, especially if there have been previous disputes between them. Such behaviour is quite frequently reported in African newspapers, and is a prime cause of the majority of divorces involving African nurses.

Extra-marital relationships carried on by nurses' husbands are the second major cause of marital friction. To a large extent, if such relationships are conducted surreptitiously, and do not affect the husband's financial responsibilities to his family to any noticeable degree, they can be ignored. But, I am told, some husbands will bring a mistress into the home

deliberately in order to humiliate a wife who is a nurse. In this case, his behaviour cannot be ignored, on account of the two-fold slight it involves, to the individual wife, and to the wife as a representative of the high-status, elite group of professional nurses. Thus such behaviour, in the same way as physical assault, is likely to lead to separation or divorce, for the nurse cannot afford to let the matter drop, without losing status by allowing her husband to treat her in this way. In these situations, she must assert her independence in order to retain her status.

It does seem possible that these problems arising from the intake of alcohol and adulterous relationships, may result, at least partially, from the nurse's elite position, which gives her a higher status than her husband, in most cases. If one considers that only 25,9% (42 of a total of 170) of questionnaire respondents' husbands were employed in what I have classified as professional occupations, including teaching, the status differential in the occupations of nurses and their husbands, becomes quite evident.

TABLE 11. Occupations of the husbands of African registered nurses.

Professional:			
	lawyer	4	
	health educator/medical aide	4	
	medical technologist	3	
	social worker	3	
	minister of religion	2	
	school inspector	1	
	registered male nurse	1	
	lecturer	1	
	private secretary	1	
	teacher	22	TOTAL: 42
Clerical:			
	clerk	43	
	public relations officer	2	
	cashier	1	TOTAL: 46
Sales:		20	
Driving Occupation (bus or taxi):		22	
Independent Business:		5	
General Labourer:		10	
Other (including 7 policemen):		13	
Unemployed:		2	
No Information (widowed/separated/divorced):		10	GRAND TOTAL: 170

In this situation, where the woman has a higher status than her husband, in most cases, against the background of the patrilineal expectations of African society, the man's behaviour is, perhaps, explicable in the following terms:

> "I think the problem is that most nurses' husbands have a complex about a woman having such a responsible position, and a high salary, because we will not just listen to them in everything. They are not prepared to accept that we are emancipated now." (This particular informant had divorced her husband less than one year after marrying him, on the grounds of repeated physical assault.)

It may be seen, with reference to these problems of alcohol and adultery, that nurses and their husbands have differing expectations regarding what is appropriate behaviour. African men, traditionally, were not expected to be monogamous. Even today, nurses readily admit that "men are weak" and find the confines of monogamy irksome, and many nurses accept that their husbands will inevitably look for sexual satisfaction outside of marriage. Their tolerance of this situation extends only to a limited degree, however, beyond which "polygynous" behaviour will result in the dissolution of the marriage. And whereas beer is an essential part of traditional social life, the modern drinking patterns of African men -- which may, perhaps, be regarded as an extension of the traditional situation -- are unacceptable to most African nurses. When the man combines extra-marital relationships with drinking to excess and wife-beating, his nurse-wife will reject such behaviour totally, and sever the bond of marriage. Her elite values do not coincide with his neo-traditional outlook, in such situations.

Marital Instability: Myth and Reality.

During the course of my research, I was told by all of my informants, without exception, that "nurses' marriages don't last". Yet it took me some

months to find just one divorced nurse, though I did find innumerable marital problems. This situation puzzled me, to the point of wondering whether the widespread belief in the inevitable collapse of marriages among African nurses was, in fact, objectively valid -- or was it a modern myth? The postal questionnaire used in the later stages of the research was intended, *inter alia*, to shed some light on this interesting issue.

It would seem, from the questionnaire results, that the number of marriages that do collapse, is small, and certainly nowhere near the proportions quoted by my informants. As may be seen from table 12, less than ten per cent (17 of a total of 172) of all the marriages ever contracted by questionnaire respondents, ended in separation or divorce. When finalised divorces alone are considered, these constitute only 7,6% of all marriages ever contracted[1].

TABLE 12. Proportion of marriages among African nurses in different age categories, which have dissolved as a result of separation or divorce.

Marriages:	Under 30	30 - 40	40 - 50	Over 50	TOTAL
A. total number of marriages:	36	85	43	8	172
B. ending in death:	2	5	5	0	12
C. ending in separation:	0	2	1	1	4
D. ending in divorce:	0	5	7	1	13
E. $\frac{(C + D)}{(A - B)}$:	$\frac{0}{34}$	$\frac{7}{80}$	$\frac{8}{38}$	$\frac{2}{8}$	$\frac{17}{160}$
F. E expressed as a percentage:	0%	8,75%	21,05%	25,0%	10,6%

From table 12, it may be seen that there is an increase in the percentage of marriages ending in separation or divorce, with increasing age,

[1] African divorce court records suggest that 6% of all civil and church marriages, in the African population, end in divorce.

suggesting that the risk of marital dissolution increases either with the increasing age of the nurse, or with the number of years that the marriage does last, or both. This increase is steady and significant, even though the very few cases in the oldest age category may not be statistically acceptable or reliable. Even given this steady increase in the rate of marital dissolution, however, the average number of marriages ending in separation or divorce is still less than ten per cent of the total number of marriages.

The questionnaire was constructed to include a check on the suspected low rate of marital break-up, since it was considered possible, if not likely, that there might be a high rate of effective marital dissolution, even if relatively few marriages actually collapsed into legal divorce. Thus a question covering all periods of residential separation was included, and it transpired that in 27,3% (47 of 172) of marriages, there had been at least one period of temporary residential segregation which, as far as is known, has not resulted in permanent separation. Certainly, in these cases, the nurse still regarded herself as married, not separated, in terms of marital status.

TABLE 13. Periods of temporary residential separation in 172 marriages among African registered nurses.

Period of Separation	Number of Marriages Involved
never separated:	96
less than six months	8
six months to one year	5
exactly one year	11
between one and two years	8
more than two years	15
(marriages ended in death, separation or divorce)	29
TOTAL: 172	

It may be assumed that those nurses who were separated from their

husbands for exactly one year, were involved in post-basic study courses away from home: in most cases, this would be for midwifery training. At least two of those who were separated for more than two years, did their entire nursing training after marrying, but were required to live in nurses' homes during their training. In one further case, the husband's political detention on Robben Island has resulted in a four-year separation. Thus, if the above cases are excluded, only 33 of the 47 cases of residential separation detailed above in table 13, may be cases of effective marital break-up. This means that a maximum of fifty (50) marriages, or 29,1% of the total number of marriages ever contracted by these respondents, may have ended as a result of separation, divorce, or effective permanent residential separation, even though, in the last case, the nurses still regarded themselves as being married. As against this figure, ninety-six (96) marriages have never involved the nurse and her husband in any period of residential separation[1].

From this evidence, it would appear that the nurses' own belief that 60-70% of nurses' marriages have broken up and ended in divorce or separation, is not objectively valid, even given the widespread existence of marital problems, discussed previously. Why, then, should this myth exist?

The belief that "nurses' marriages don't last" may be used by an African nurse, to legitimise her stand of independence vis-à-vis her husband, and also to insist on her own minimum standards in the home. If her marriage should come to an end, then, this is not seen as cause for individual shame and blame: for, in terms of the myth, it was only to be expected that the marriage would not last. Thus one informant[2], married to a matriculated clerk, justified the failure of her marriage with reference to this myth, when she

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[1] It should be noted here that husbands who are sales representatives may be required to travel away from home at regular or irregular intervals, but such travelling cannot be classified as "temporary residential separation" in the sense in which I have used this term.

[2] See chapter eight: "Elizabeth".

flatly refused to go and live in a two-roomed "shack" which had crumbling walls and no running water. Her husband wished her to leave the semi-detached flat she was renting, in order to save money to build their own home. He refused to live on the mission with her, and she refused to move to his "shack", telling him that if he expected her to act thus, he could consider their marriage over and get out. She was supported in her stand by her elder brother, himself a headmaster of an urban secondary school, and a member of the elite stratum. In fact, this brother urged her to commence divorce proceedings against her husband (who did leave) on the grounds of desertion! Afterwards, she had this to say:

> "Look, I wanted very much to have a happy, settled family life, and to set an example, especially to young nurses, because nurses' marriages don't last. But when E____ came with this nonsense about moving to C____, to that filthy shack he calls a house, then that was too much. How could I bring my children up in such a place? Not only for myself, but for their sake I will <u>not</u> live in that shack...Even though I still love him, I am not prepared to give in to him on this point. <u>I will not budge an inch</u>! So — he has left. And I miss him, but really, I do not feel ashamed about what has happened. As a nurse, I must expect these things."

Because of her (potential) financial independence, the nurse need not continue an unsatisfactory marriage, for she is able to support both herself and a small family on her own salary. The status aspects of marriage (which were discussed in chapter six) are satisfied once the nurse has been married in church, at much expense, and has born a child, thus demonstrating her fertility. Once these requirements have been met, the major goal of marriage has been achieved, and should the marriage flounder later, there is no reason why she, the nurse, should sink with it. Most important of all is the fact that the children <u>must</u> be brought up in accordance with her own ideas and values. Where her values clash with those of her husband, she must ensure that her children are clean, properly fed, adequately clothed and educated, so that they grow up in an environment that accustoms them to the western-based

elite life style. Her primary responsibilities are to her children: her husband is already adult, and if he is incapable of looking after himself as he should, then that is not her problem, but his.

In the light of the problems experienced by nurses in their married lives, and the existence of this myth which may be used to justify marital dissolution, how does it happen that such a large proportion of nurses' marriages do hold together, in many cases apparently happily? Before attempting to answer this question positively, it is necessary to examine the material in order to dispose of certain negative factors, or factors that do not, apparently, work either toward or against marital break-up.

Examination of the data available for the seventeen cases of legal divorce or recognised separation, yields little conclusive evidence regarding the part played by the educational qualifications and/or occupations of the nurses' ex-husbands. The distribution shown in table 14 does not differ significantly from the figures given in tables 10 and 11 for husbands' educational qualifications and occupations respectively.

TABLE 14. Educational qualifications and occupations of African nurses' husbands, in cases of separation and divorce.

Educational Qualification		Occupation	
post-matriculation	1	professional	2
teaching qualification	2	teaching	2
matriculation	5	clerical	4
form IV	1	sales	2
junior certificate	4	labourer	2
form I/standard 7	1	policeman	1
standard 6	2	unknown	4
unknown	1		
TOTAL:	17	TOTAL:	17

In eleven of these cases of separation or divorce, the husband had equivalent or higher school education than the nurse; in five cases the nurse's school education was higher than that of her husband; and for the remaining case the information was not given. It would appear, then, that the termination of marriage is unconnected with the man's schooling or occupation, and there is no significant clustering within the ranges of these two factors.

There does appear to be some relationship between the nurse's age at marriage, and later dissolution of the marriage, however, although it is impossible to do more than indicate potential relationships in view of the small numbers involved. In the seventeen cases ending in separation or divorce, seven marriages were contracted by nurses who were less than twenty-four years of age (42% compared with approximately 33% of the figures for all marriages) and five more were contracted after the age of thirty (30% compared with less than 20% of the total figure.) It would seem, then, that both early and late marriages ages increase the likelihood of later separation or divorce.

Finally, the barely significant correlation between non-payment of lobola and later marital break-up, has been shown previously[1].

The most positive association seems to be between age at marriage and the later failure of that marriage, and this factor exists in western societies as well as among African nurses and would, therefore, appear to be of little specific explanatory value in this context.

Thus it seems possible that the majority of marriages contracted by African nurses, probably continue as a result of the nurses' occupation and

[1] See chapter six, page 120.

elite status. Nursing salaries are relatively high by African standards, in South Africa, especially for women, and her professional qualification more or less assures the nurse of a job anywhere, at any time. Marriage to a qualified nurse, then, represents a form of security, insurance even, to the average, non-professional African man. Thus the husband has a vested interest in continuing his marriage to a nurse, in spite of the problems he may encounter in such a marriage. In this situation, he is unlikely to divorce his wife.

There appears to be some support for this point of view. From the cases of one divorce and one separation among my respondents, and two newspaper reports of divorces involving nurses, it would appear that the nurses themselves are responsible for the divorce suits. In all four of these cases, the nurse has been plaintiff, suggesting that divorce is, perhaps, more frequently the result of nurses' dissatisfaction with their husbands, than vice versa. This evidence lends support to the idea that, in cases of conflicting values between a nurse and her husband, it is in the nurse's interests to sue for divorce, and in the man's interests to continue the marriage, even if this means toeing the line his wife lays down. Paradoxically, then, the nurse's elite status resulting from her professional position, works both for and against the continuation of her marriage to a non-professional, non-elite man, and in the final analysis, it may well depend on personality factors as to whether any particular marriage is continued or dissolved.

As an incidental point, it is perhaps worth noting that, in cases of marriage under common law, if an African woman sues, successfully, for a divorce from her husband, any lobola that may have been paid, is not returnable. This may be one reason why a nurse's kin, especially in the rural

areas, will accept a divorce instead of pressing for the continuation of the marriage: they do not stand to lose by such a divorce. Once again, this situation reflects the nurses' distinctive social position, for relatively few African marriages are recognised as valid under common law. Most African marriages are recognised in terms of tribal law only, where the lobola payment, far from being regarded as a peripheral detail of no legal significance, is the factor that legalises the marriage, and actually constitutes the marriage in legal as well as social terms. It is possible, then, because nurses conclude marriages under common law, to regard the nurse's behaviour in marriage, as being beyond the reach of traditional sanctions, and this legal position buttresses her elite status.

In conclusion, the issue of marital dissolution among African nurses, may be summed up as follows. In keeping with their elite status, nurses contract (monogamous) marriages under Roman-Dutch (Common) Law, either by civil rites or in a religious ceremony. This legal status of their marriages means that the considerable sums of money paid as lobola for nurses, are non-returnable by the nurses' kin, should a nurse sue, successfully, for a divorce from her husband. Thus in the event of the dissolution of the marriage, the important traditional sanction of return of the lobola, has been removed. Thus the incentive for the woman's kin (to whom the lobola is paid), to press for the continuation of the marriage, is removed. In addition, the nurse herself is financially independent of her husband, and can, therefore, afford to discontinue the marriage. Furthermore, there exists, among African nurses, a myth (that "nurses' marriages don't last") which excuses, if not justifies, the dissolution of their marriages. But despite these factors, few nurses' marriages actually do dissolve, and the reason for this continuation probably lies in the security offered by a nurse-wife to non-professional, non-elite African men.

CHAPTER EIGHT

THE LIFE HISTORIES OF THREE AFRICAN NURSES

In previous chapters, I have dealt with the implications and consequences of the elite status of African nurses, in general terms. I now wish to consider some of these points in relation to the lives of particular individuals, in order to provide a more complete and more realistic picture of what this elite status may entail for the individual nurse. Therefore, I have included, in this chapter, the life histories of three of my regular informants. Each of these three Zulu women lives a different life, under different circumstances, with different interests, yet there is a common theme linking all three: each shows different facets of elite status, within the overall framework of elite identity.

Case A, Elizabeth.

At the time of research, Elizabeth was thirty-five years old (she was born in 1935). She is separated from her husband, and lives with her two young daughters (aged, at the time, three years and a few months, respectively) and her maid, in a mission-owned house. At the time I knew her, Elizabeth was working in the operating theatre of St. Mary's Hospital.

Elizabeth holds three nursing qualifications, in general nursing, midwifery and operating theatre technique. She trained, initially, at the Benedictine Hospital, Nongoma (a Catholic mission hospital) and, later, at Edendale Hospital, outside Pietermaritzburg.[1] She has worked at Nongoma,

[1] Until April 1970, Edendale Hospital was controlled by the Natal Provincial Administration: it is now under the control of the Department of Bantu Administration, since it is situated in a Homeland area.

Eshowe, Port Shepstone, Pietermaritzburg and Durban, in both mission and provincial hospitals. Like most of her colleagues[1], Elizabeth has been exposed to the influence of a number of different hospitals. In all, she has moved between different hospitals nine times, in response to the demands of post-basic training, her mother's illness, a desire to work in provincial hospitals and, finally, the desire to settle down in order to raise her family.

As may be seen from her genealogy (Case A: Elizabeth's Genealogy), Elizabeth was the third child and only daughter born to her parents. She is the youngest in her sibling group. Her eldest brother, who failed standard seven at school, is a police detective, who lives in Umlazi and works at Isipingo (on the South Coast). He is married to an ex-domestic servant, though their only son was five years old before they eventually married. Elizabeth's second brother obtained his Higher Primary Teachers' Certificate before leaving school, and went on with his studies through correspondence schools. Eventually he graduated with a Bachelor of Arts degree from the University of South Africa. He is married to an ex-teacher, and they have six children.

Elizabeth's mother was brought up as a practising Christian. Her father (Elizabeth's maternal grandfather) was an assistant to a Methodist (European) minister. Elizabeth's maternal grandmother died two months after the birth of her sixth child, and Elizabeth's mother (the second child and eldest daughter) was left to raise her younger siblings, and thus had to leave school before completing standard two. But she had worked for intermittent periods as a domestic servant on European farms, and had thus become aware of the importance of being able to understand and speak English, and she

[1] Cf. table 1, p. 4.

determined that any children she might have, would be educated. When Elizabeth's mother had discharged her obligations to her younger siblings, she married, in 1928, at the age of thirty-seven.

Elizabeth's father came from a pagan family. Both of his parents were pagan for the greater part of their lives, though his mother (Elizabeth's paternal grandmother) was converted to the Methodist church in middle age, and all of her children were baptised in the Methodist church when she joined it. According to Elizabeth, however, they were nominal Christians only, despite their western dress. In her old age, Elizabeth's paternal grandmother came under the influence of Isiah Shembe, and left the Methodist church to join the Shembe sect. Elizabeth's father, who never attended school as a child, left the country at an early age, to work in Pietermaritzburg. Here he attended night school, where he completed standard two successfully. Eventually he became an induna with the South African Railways Police. He died in 1957, in Pietermaritzburg.

It may be seen, then, that although Elizabeth comes from a predominantly Christian background, virtually all of her immediate kin are semi-literate and, with the exception of her second brother and his wife, non-elite. As I have described in chapter five (pp. 98 - 103), the pattern of linkage of nurses to non-elite kin, is common. The non-elite family background is indeed one important reason why, in the case of elites in modern Africa, analysis of their position in terms of the concept of social class, is premature.

For the first few years of her life, Elizabeth's activities did not differ from the traditional Zulu rural pattern to any great extent. On the farm at Camperdown, and later at Umzumbe (on the South Coast), she fetched wood and water like any other Zulu girl. However, her Christian background

became significant when Elizabeth was old enough to attend school. Until the end of standard five, she attended the Umzumbe Mission School, which was run by the Free Methodists. Her mother then wished her to leave school, fearing that she would become "spoiled" by further education, and neglect her parents in favour of town living. However, as a result of the combined protests of Elizabeth's eldest brother (who had himself left school after failing standard seven) and her young Xhosa (female) teacher, her mother was prevailed upon to allow Elizabeth to continue with her schooling, which she did at one of the better-known Catholic boarding schools, St. Joachim's, at Umtwalume (also on the South Coast). Elizabeth failed her Junior Certificate once, but was sent back to school to repeat that year and pass, which she did in 1953. Beyond standard five, Elizabeth's education was financed by her eldest brother alone.

Elizabeth's parents expected her to become a teacher, as had her second brother. However, she eventually decided to enter nursing, partly as a result of the influence of the nuns who taught her at St. Joachim's, but also because of the objective advantages nursing offered over teaching as a career, such as pay during training, uniforms, no tuition fees, and work in a modern hospital rather than among "raw" people in the bush. In 1954, at the age of nineteen, Elizabeth began her nursing training at Nongoma. Because she failed the South African Nursing Council Preliminary Examination (at the end of her first year), her training extended over four years. Elizabeth was registered as a trained general nurse, with the South African Nursing Council, in May 1958, at the age of twenty-three.

In the early nineteen-sixties, Elizabeth came into contact, for the first time, with people who regarded her primarily as an African rather than as a trained nurse. At Port Shepstone, for example, she lived with other

unmarried nurses in the Non-European Nurses' Home, which was an old house. Her request that the filthy, torn curtains in her room be replaced, was met by the (European) caretaker's reply: "Who does she think she is? A European?" The food served to the African nursing staff consisted largely of samp and mealie porridge, because "they don't eat anything better at their homes". Such attitudes came as a surprise to Elizabeth, who had had extended contact, from her earliest schooldays, with missionary Europeans "who were trying to uplift the Africans". In view of these experiences, it is hardly surprising that today Elizabeth distinguishes very clearly between Europeans who are "white" and those who are "white-white". (This latter category encompasses all those Europeans who display overt racial prejudice.)

While she was single, Elizabeth went out with many different men, a fair number of whom apparently expressed interest in marrying her. She is somewhat unusual among nurses, however, in that she prides herself on having kept all of them as friends and nothing more, not having entered into sexual relationships with any of them, "... so that today, I can look any one of them in the eye and not feel ashamed".

However, Elizabeth did eventually marry, at the fairly late age of thirty-one, and thus put an end to her family's speculation: "... they were always wondering who I would bring home and say 'We are getting married'". She had met James in 1962, through the machinations of a mutual friend (also a staff nurse), and they decided to get married in 1963. James could not find sufficient money to meet the lobola demanded by Elizabeth's eldest brother (who became her guardian after her father's death). Elizabeth and James quarrelled about this question of lobola, and parted. Three years later, however, James contacted her again, and they decided to marry after all. This time, James could and did provide the R500,00 requested by Elizabeth's eldest

brother. In fact, the amount agreed upon was R560,00, but it was decided, by Elizabeth's brother, that the last R60,00 should be regarded as the presents which she should, according to Zulu custom, have given to James' relatives, and this sum was, therefore, cancelled. Part of the lobola was used to cover the wedding expenses, while the remainder was kept by Elizabeth's eldest brother, who had financed her schooling from standard six, supplied her with pocket money, and paid her travelling expenses during her nursing training (her salary, as a student, was so low that she could not meet the exponse of travelling by train and bus from Umzumbe to Nongoma).

In general, Elizabeth approves of the lobola custom, since she feels that it acts as a curb on the polygynous inclinations of men.

> "And how else can you believe a man if he says he loves you, at that time? Only if he is prepared to make sacrifices to pay lobola."

However, Elizabeth strongly believes that the present form of lobola should be altered, so that the girl herself should have the final say regarding the distribution of the money, which she thinks should be used to cover the wedding costs, while the remainder (if any) should go to those who have raised and educated the girl. However, she objects very strongly to the practice of charging an "education fee" as part of the lobola: "That is trash -- rubbish!" Thus, although Elizabeth accepts this African custom, it is obvious that her ideas regarding the form this should take, differ quite radically from those of most Africans.

When agreement regarding the lobola had been reached, Elizabeth put on the engagement ring which James had bought in 1963, and which they had had blessed, secretly, at a private ceremony. Elizabeth's mother had kept this ring for her daughter, following Elizabeth and James' quarrel. They did not

hold a formal engagement party.

Elizabeth described her wedding, which took place at Umzumbe in September 1966, as a "two-session affair", which catered for two different groups of people. Thus Elizabeth's wedding followed the general pattern of nurses' marriages discussed in chapter six. The Catholic mission church was packed with Africans and Europeans alike. The guests came from Elizabeth's home (her brother had hired a bus to transport relatives), from the mission, the school, and the hospital in Port Shepstone, where she was working at the time. Two of her four flower girls were the daughters of a European nursing colleague (reflecting Elizabeth's fairly extensive social contact with Europeans), and the other two were the daughters of her second brother. Her bridesmaids were both classificatory kin, one a staff nurse, the other an auxiliary nurse at Port Shepstone Hospital. Elizabeth herself (to judge from her wedding photographs) was a happy, even smug, bride!

After the Nuptial Mass had been celebrated, the first "session" of the celebrations was held. The guests proceeded to High Tea in the Convent Hall, and this reception lasted for just over an hour. Tea, sandwiches and cake were served, and the wedding cake was cut. (Elizabeth kept the top layer of the three-tiered cake, for the anticipated Christening of her first child.) This High Tea catered for the educated, professional friends, African and European, of the bridal couple. All of the proceedings, including the speeches, were conducted in English.

When High Tea was over, and Elizabeth and James had signed the marriage register, the proceedings moved to Elizabeth's home, three miles away in the country, where the second "session" of celebrations was to be held. As she stepped out of the bridal car, Elizabeth was called upon to dance: a few

shuffling steps substituted for the traditional dance, and then she pleaded that her long, white wedding gown[1] was impossible to dance in!

Country folk, kin and non-kin, came from far and wide to attend this celebration. They brought beer and food -- samp, rice and bread -- to augment the stocks Elizabeth's brother had purchased. Some four hundred guests were fed from the beasts that had been slaughtered the previous evening: the mula[2] cow, presented as a gesture of honour to Elizabeth, the only girl in a family of boys; a second cow, also in Elizabeth's honour, on account of her good behaviour while in the family; and two goats, one to thank James for the lobola, and the other for the umkhongi in recognition of his services. The food was served by the professional people, the nurses and the teachers, to the rural guests where they sat -- the men in the cattle kraal, the old women in their hut, the younger guests outside, and the wedding party at the table of honour, in a separate hut.

In the late afternoon, Elizabeth and James changed into everyday clothes and left the scene of continuing celebrations. They walked over to the home of one of Elizabeth's classificatory kin, where they spent the night, and were served breakfast in bed the following morning -- an interesting departure from Zulu custom!

On the following (Sunday) afternoon, they travelled by car to Durban. They had supper that night with James' parents (just the four of them), but stayed only for supper. James, at the time, was employed as a (non-elite)

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[1] Elizabeth's wedding dress and accessories, plus the dresses for the bridesmaids and flower girls, cost her R105,00, of which James refunded her R70,00.

[2] I cannot find any mention of such a beast in Krige (1950) or Vilakazi (1965). The name was, however, spelt out for my benefit by this informant, and probably derives from the ukwomula custom described by Bryant (1905:475), whereby a goat should be slaughtered by a girl's father during her puberty seclusion, to ensure her fertility in marriage.

caretaker at a Westville sports club, and was provided with accommodation. Elizabeth stayed with him for a week, on holiday, before returning to work at Port Shepstone.

When she went on maternity leave at the end of May, 1967, Elizabeth went home to Umzumbe to stay with her mother. According to Zulu custom, her first child should have been born at her parental home, but Elizabeth preferred to deliver in hospital. Her first daughter was born by Caesarian section at Port Shepstone Hospital, in late July (1967). After leaving the hospital, she returned to stay with her mother for the rest of her maternity leave.

Elizabeth returned to work in November 1967, to resign her post. She felt that the time had come to settle permanently, and she wished to serve the Catholic missions in some way. Because James was working in Durban, she came to St. Mary's, but this move was not in her own best material interests. She had been a nursing sister at Port Shepstone, and here she had to accept a staff nurse's position, which, in addition to a loss of authority and prestige, also meant a drop in salary.

At first, living conditions were poor when measured against Elizabeth's standards. Three families shared bathroom and toilet facilities, and each family had only two rooms for its own use. However, after some months had passed, Elizabeth managed to secure her present accommodation, a semi-detached "flat" comprising kitchen, lounge, two bedrooms, bathroom and separate toilet, for which she pays a rental of R20,00 per month. Her home is furnished adequately, but not expensively. The furniture, all of which belongs to Elizabeth herself, includes (in the kitchen) an electric stove and refrigerator, a small gas stove (used before their electricity was connected), two kitchen

cupboard units and a panelyte table-and-chairs set; (in the lounge) three occasional chairs and a divan (in place of the more usual lounge suite), a writing table, a nest of coffee tables and a small carpet; a bedroom suite, single bed, cot and two rugs. A portable radio substitutes for the more usual radiogram cabinet. Elizabeth disapproves of using hire purchase facilities, in contrast to most of her colleagues, and her salary allows few luxuries without using credit, hence her home is less impressive than those of most nurses. Her life style is nevertheless that of a member of the elite.

James, the husband from whom Elizabeth is separated but not yet legally divorced, has rarely lived with his family of procreation. James is urban-born and urban-bred, a matriculant with no professional qualification, who has held a number of jobs, clerical and other, since his marriage. At one stage, he was unemployed for some months, and because he had put his savings into fixed deposit with a building society, Elizabeth was solely responsible for family finances, a situation which she did not appreciate. James' frequent changes of job have been a source of dispute in the past, and they illustrate the problems which may be faced by an educated, but professionally unqualified, African man in the South African employment structure. The contrast between James and Elizabeth in terms of their respective job security and earning capacity, is apparent. James earns less than Elizabeth, and she thinks he has "a complex" about this situation.

During the course of my fieldwork, James joined his wife and daughters on the mission, supposedly on a permanent basis. But within months, it became clear that their marriage was finally finished. Why? What caused this break-up to occur? The factors of tension arising from employment and financial issues have already been mentioned, but other factors have important bearing on the dissolution of their marriage, as well.

Elizabeth regards herself as hard-headed and independent, and sees the first of these attributes as a personal idiosyncracy, the second as the hallmark of a nurse. These attributes are apparent in her behaviour most of the time. She refused, point-blank, to live with James' parents under any pretext at any time, before agreeing to marry him. She refuses to have alcohol in her home, with the exception of the odd beer or bottle of wine on celebratory occasions -- let alone brew beer herself. During the fieldwork period, she made use of her pregnant condition to refuse to look after James' father's sister's husband, who was dying of lung cancer at home in Clermont, explicitly denying that her husband's kin had any right to expect her to undertake such nursing duties in addition to her own job. Elizabeth expounded her own attitude in the following words:

> "Look, I am an African. But just because I am an African does not mean to say I must accept <u>everything</u> that is African custom because it <u>is</u> custom. I hold certain principles, and act according to these, and many of these principles do <u>not</u> agree with African custom...For instance, I will <u>never</u>, <u>never</u> brew beer in my house..."

Some of Elizabeth's "principles" derive from her nursing training, while others may be traced to her religion. Elizabeth voluntarily changed her affiliation from the Methodist to the Catholic church in 1955, at the end of her first year of nursing, and she explicitly states that, whatever the appearances to the contrary, she is deeply religious, and her religion means a good deal to her. She attends church daily. Certain logically unacceptable ideas in Catholic doctrine, she refuses to think about, on the grounds that such mysteries of faith are closed to Man's knowledge, and must be accepted without question. Whether such ideas are indeed accepted, is doubtful, of course, and I would suggest that, to a person who thinks as deeply as Elizabeth does on most issues, practical considerations have a bearing on

such acceptance. For instance, the doctrine of the Trinity has theoretical significance, whereas the number of children one has, is an intensely practical issue. In addition to accepting Catholic doctrine, Elizabeth is a nurse, and on some issues (such as the number of children one has), Catholic and nursing values clash among Africans.

> "As a nurse, I see the necessity for being able to feed and educate all the children you have -- this is good. But for myself, such methods (that is, of "artificial" contraception) are not for me, from my religion."

As I have indicated earlier, the majority of African nurses desire and have fairly small families. Non-Catholic nurses, in general, express a desire for small families, whereas Catholic nurses say they would care for "as many children as God sends", though the more forthright ones add "but not happily". Despite the psychological conflict it caused her, one of my Catholic informants actually underwent tubal ligation after having two children (see p. 103). Indeed, Elizabeth herself expressed a desire for four children when she had only one, but when the second arrived, she commented, twice, "I think she will be the last", and merely smiled when reminded of her initial estimate.

Elizabeth's first child was born less than a year after she married. Probably as a result of her residential separation from James, her second child was born three years later. Her most fertile years are past now, but with her husband living with her, and modern techniques of birth control denied to her, Elizabeth could indeed have a fairly large family. Thus her religious principles are, to some extent, in conflict with her values as a nurse, and it would appear to be possible that this conflict may have had some (latent) bearing on the break-up of her marriage, though I do not wish to over-emphasise this possiblity.

The final breaking point in the marriage came when James demanded that Elizabeth relinquish her R20,00 per month mission house, and move from the mission station to his home at Clermont. Her refusal was absolute: the house had two rooms, crumbling walls, and no running water. James proposed that they would save money to build a decent house by living in the present delapidated one, rather than wasting it on a high-rental mission house, however well-appointed and convenient this was for Elizabeth's purposes. Elizabeth refused to consider the proposition, and told him he could either live with her on the mission, or regard their marriage as over. She even called upon her second brother to arbitrate in the quarrel. (Not the eldest brother, who had received the lobola and who is a police detective, but the second brother, the graduate headmaster of a secondary school in the Durban area, and himself an established member of the elite stratum.) He supported her stand, and James packed his belongings and left[1].

Elizabeth regrets the loss of the man she loved sufficiently to marry in the first place, but this loss is less than that which she stood to lose had she acceded to his demands. She has a small family, which she can support, unaided, in the manner she considers necessary for decent, "civilised" living; she retains her elite status, which would have been jeopardised by living in a "shack"; she retains her independence, in accordance with her colleagues' expectations; she has had the status-enhancing white wedding. All she has lost is a husband, not a member of the elite, whose values conflicted, at least in some respects, with her own; and the possibility of a large family, which, while approved by her religion, would have detracted from her elite life style, stretched her financial resources beyond their limits, and limited her "independence", particularly in financial matters.

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[1] See chapter seven, pp. 143-4.

I would suggest that the break-up of Elizabeth's marriage is partly the result of her elite values, the "principles" which guide her actions, and which derive, ultimately, from her professional knowledge and realistic assessment of practical issues. Partly, however, the break-up has been the result of Elizabeth's own personality, for the lasting impression one gains from Elizabeth is strength of character and almost rigid determination. A sense of purpose and rather quiet determination are characteristic of most African nurses, but, as Elizabeth herself admits, she is "hard-headed". Thus where other nurses might, perhaps, have allowed their marital problems to continue, Elizabeth brought hers to a head, and precipitated an open breach of relations between James and herself. It is worth noting that, in her stand against her husband, Elizabeth enlisted the assistance of the only other member of her family who has elite status, despite the fact that the person who receives the lobola is customarily regarded as the "guardian" of the marriage. The very obvious reason for this (since her oldest brother was equally accessible), lies in the differing values of elites and non-elites, discussed previously (in chapter four). Elizabeth knew that her second brother would support her stand on the housing issue, and she also knew that his status was such that her husband would find it very difficult to reject his arbitration and judgement.

While Elizabeth is, perhaps, somewhat exceptional as far as her personality is concerned, much of her background is common to most African nurses. There are obvious similarities between Elizabeth's life and that of another of my informants, Mary-Jane, despite some rather superficial differences, such as their membership of different churches, residence in different areas (mission station and urban township), training at different hospitals, and so on.

Case B. Mary-Jane.

At the time of research, Mary-Jane was thirty-two years old. She was born, in 1938, on an Anglican mission station near Ladysmith, in northern Natal, and was the seventh child and third daughter in her family. Mary-Jane is married and has three children (boys aged eight and seven, and a girl of five). She holds the post of staff nurse at Clairwood Hospital, and looks forward to promotion to the post of sister in the fairly near future. She and her family live in a township house in Lamontville.

As may be seen from her genealogy (see Case B: Mary-Jane's Genealogy), Mary-Jane recognises large numbers of kin, patrilateral and matrilateral, as does Elizabeth. As may be seen from table 4 (on p. 99), these two informants (numbers six and eight) recognised the largest numbers of kin. Through their kin networks, both Elizabeth and Mary-Jane are linked extensively to non-elites.

Mary-Jane's mother, like Elizabeth's, was a rural wife who went no further than standard two at school, although she was born into a Christian family. Mary-Jane's father also came from a semi-Christian family, in that his mother (Mary-Jane's paternal grandmother) had joined the Anglican church, even though her husband did not. The fact that affiliation to Christian churches was less well-established in Mary-Jane's father's family, is reflected in her genealogy: both her father's elder brother, and her father's father's brother, were polygynists.

Mary-Jane's parents are now both deceased. Her mother died in 1966, but her father died in 1940, in Johannesburg, where he worked as a night-watchman. He left his widow with seven young children and an eighth on the way. Only the two eldest sons could assist their mother financially, particularly as far as

the education of the younger children was concerned. But finances were not Mary-Jane's mother's only problem. It appears that there was some pressure exerted upon her, after her husband's death, to enter into a leviritic union with her husband's (polygynist) brother, under the Zulu ukungena custom, for this man ran the homestead and farm. Partly as a result of this situation, and partly because of her large family, Mary-Jane's mother was persuaded by her own widowed sister to join a relatively new and unknown religious sect.

The Assemblies of God had been founded by the Rev. Nicholas Bhengu, in East London. From there, he had extended his proselytising activities to Johannesburg and Durban, and to some smaller centres as well. Mary-Jane states that her mother left the Anglican church to join the Assemblies of God, for two reasons: firstly, she had a large number of small children, for whom (western or non-western) medical expenses would be large, and Bhengu preached that prayer, rather than medicine, was effective in healing. Secondly, to become a staunch churchwoman, in the close-knit organisation that is characteristic of Bhengu's church, was a check on any temptation to become "a loose woman" (Mary-Jane's own phraseology).

Very likely her affiliation to the Assemblies of God was one reason why Mary-Jane's mother continued the struggle to educate her children, for Bhengu emphasised the necessity of education[1]. However, had it not been for her teacher (an African man) at the local school, Mary-Jane would have had to leave school at the end of standard five. This teacher felt that she should continue with her education, and he financed her schooling as far as the Junior Certificate, at St. Hilda's, a well-known Anglican mission (boarding) school, near Ladysmith.

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[1] See Mayer (1963:193 - 205).

After passing the Junior Certificate at the end of 1956, Mary-Jane applied to the McCord Zulu Hospital to train as a nurse. Her eldest sister had trained at this hospital and, as Mary-Jane put it, "nursing was the thing at that time". However, she had to wait at home for six months before the hospital could accept her.

During her training, Mary-Jane made firm friends with two of her fellow students, a Pedi girl from Johannesburg, and a Zulu student from Inanda (Mary-Jane is herself Zulu). She still corresponds with the former, who is now married and settled in one of the smaller Reef towns. These friendships reflect the intertribal pattern found among the majority of my informants. Also during her training, Mary-Jane met the young man who was later to become her husband. At the time, Peter was studying for his matriculation examinations at Adams College, near Amanzimtoti. They met at one of the annual Conventions of the Assemblies of God, in East London, having accompanied their respective mothers to this Convention.

Mary-Jane completed her nursing training, and was registered with the South African Nursing Council, as a general nurse, in May 1961, at the age of twenty-two. Just before the examination results were published, Mary-Jane and Peter became engaged, and held the first engagement party in her home district[1]. She was mocked by her colleagues for contemplating marriage at such an early stage of her career, but two months after their engagement party (when Peter had completed the total lobola payment of R270,00), in late June, 1961, they were married.

The church wedding was held at Mary-Jane's home, where the marriage

[1] See chapter six, pp. 122-3.

ceremony was conducted by the local Baptist minister[1]. An interesting feature of the actual marriage proceedings concerned the signing of the register, in the church itself. As Peter went up, alone, to sign, his four groomsmen and his relatives sang: when Mary-Jane went up, after he had finished, her bridesmaids and relatives sang. After the service was over, the bride's group was adjudged the better in song. This incident has obvious parallels with the competitive singing of the bride's and the groom's parties, in traditional Zulu marriage ceremonies.

After the church ceremony, everybody adjourned to the bride's home, where Mary-Jane and her four bridesmaids (two of her nursing friends, her younger sister, and a classificatory sister who was a teacher), paraded around the homestead for the benefit of the guests. Afterwards the older women took her aside "and lectured me on what a wife must do, and how I must behave and all that. And did they lecture! Hau!" When the lectures were over, Mary-Jane was assisted out of her long white lace wedding gown, and donned a silk suit, hat, gloves and high-heeled shoes. Despite her sophisticated western dress, when the traditional dancing started, she was required to perform alone. "Well, I tried, but I don't think it was very successful!" During the afternoon, meat (from an ox, a couple of goats, and numerous chickens, which had been slaughtered the previous evening) and rice were served to the guests.

In the evening, the reception was held in the school hall, where their engagement party had been held previously. Only cool drinks and light refreshments were served on this occasion, which was primarily for the bridal couple and their educated friends who had attended the wedding. The dancing

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[1] Although Bhengu's Assemblies of God is usually regarded as an independent sect, it has close ties of affiliation with both the European Assemblies of God, originating in America, and the Baptist church.

at the reception was of the western, ballroom variety, as opposed to the previous traditional style. In the details of Mary-Jane's wedding, the pattern of dual celebration -- traditional and elite -- is again evident.

On the day following the church ceremony, Peter and Mary-Jane, their attendants, the bride's four brothers and some other close relatives (but not the bride's mother) all travelled from Ladysmith to Adams, for the celebration at Peter's home. Again there was a feast, attended by his kin and others from the area, for which beasts had been slaughtered. However, because Peter's father was already deceased, Mary-Jane states that she was exempted from the traditional behaviour expected of the umakoti: "It was just his brothers, you see, and I already knew his mother from church". The newly-weds spent the remainder of the Sunday at Peter's natal home, but by Sunday evening, they were installed in their own home in Clermont, along with the furniture[1] Mary-Jane had taken with her on marriage (a bedroom suite and a dining room suite. These items have long since been traded in on newer items.)

Shortly after her marriage, Mary-Jane began her midwifery training, again at McCord's, and by the time she had finished the year-long course, she was herself six months' pregnant. Just after the birth of their first son (at McCord's), in September 1962, Mary-Jane and Peter moved into their present house, in Lamontville, which they are purchasing on the municipal "buying scheme". Before they moved in, they had electricity installed at their own expense, and since then they have been improving the four-roomed house as their financial position permits. At the time I knew them, all of the floors had been marley-tiled, the walls were fully plastered, interior doors had

[1] In contrast, Elizabeth took no furniture with her to her new home: "My certificates are my furniture. Later, if we need it, they can earn money for me -- as they have done up to now."

been fitted, and the kitchen walls had been tiled. They had also put in a stainless steel sink and cupboard unit, and there were pelmets above all the windows. Their furniture (bought on hire purchase) is in keeping with the improvements made to the house: a medium-sized refrigerator, stove, panelyte kitchen set, lounge suite, display cabinet, radiogram, main bedroom suite, and twin beds and a wardrobe in the children's room. The house is smaller than Mary-Jane would ideally like, since they have three children and a maid, but they are hoping to buy land and build their own home in Umlazi within the next ten years.

Mary-Jane and Peter are active members of their church, and most of their social activities revolve around their church membership. The fact that she is the only trained nurse in the Umlazi-Lamontville congregation of the Assemblies of God, gives Mary-Jane added prestige within this organisation, since she is often invited to deliver lectures (on hygiene, pre- and post-natal care, artificial feeding, and so on) to her co-members of the Mothers' Union. Mary-Jane is the only nurse I knew who played an active role in the Mothers' Union of her church. She attends these meetings in her nurses uniform (the others do not wear any uniform), and her knowledge and position are held up as examples to the other women[1].

Their involvement in church affairs has been to their financial advantage. Even though they both contribute tithes amounting to ten per cent of their respective incomes, to the church, Peter and Mary-Jane have responded to Bhengu's exhortations to save their money and make as much as they can by legitimate means. Each year they think up different ways of collecting extra money: in 1970, Peter was collecting old newspapers and

[1] Cf. chapter four, pp. 84 - 88.

reselling these to shopkeepers, while Mary-Jane had bought a large supply of various types of brushes, on a buying order supplied by her brother-in-law (a store-owner in Umlazi), and was selling these to her colleagues at the hospital. They had accumulated over R50,00 from these activities in 1970. The income they gain from these activities is banked in a fixed deposit account, and is used for capital expenditure only.

Because they own a car (a small D.K.W.), Peter and Mary-Jane are fairly mobile. They visit Peter's people at Adams once or twice a month (according to Mary-Jane, the farm is a good supplementary source of fresh fruit and vegetables, thus cutting their marketing expenses). Church activities take up most of their free time, but they do occasionally visit Mary-Jane's two married sisters, who are living in Umlazi, for social, non-religious purposes. Very occasionally they visit her brother (a labourer) and his family, in Kwa Mashu, and perhaps once a year they may visit her eldest sister, who is also a registered nurse, in Pietermaritzburg. Kin links are thus maintained, but Mary-Jane has a number of friends among her colleagues at Clairwood Hospital, where she is presently working, with whom she goes to town and to market, and very occasionally visits.

Like most of her colleagues, Mary-Jane has had trouble, in the past, in retaining the services of a domestic servant (see chapter five). Her last maid walked out one day, giving no notice of her intention to leave, and a fellow member of the Assemblies of God, recommended to Mary-Jane another church member. Nomsa, an illegitimate child who had been brought up by her mother's kin, who lived some twenty miles from Pietermaritzburg, had been neglected, and had never attended school. However, Mary-Jane was desperate for domestic assistance, and employed her. That was some nine months before I met Mary-Jane,

and by the time I knew them, Nomsa (then aged twenty-four) had become quite an accomplished cook, who baked bread every other day in addition to cooking most of the family meals, and even baked cakes and other recipes taken from, among others, Femina[1]. Mary-Jane, who now pays Nomsa R11,00 per month, is so pleased with her that she is considering paying for her to attend night school, for the two boys are already attending school, and have had to be reprimanded severely for mocking an adult who knows less than they do.

As I have mentioned earlier, it seems that a close social relationship, which may even be translated into a kinship idiom[2], is necessary for a domestic servant to remain in the employ of an African nurse. In this particular situation, for example, Nomsa would be foolish in the extreme were she to jeopardise Mary-Jane's trust in her, in view of their common membership of a closed religious group. Likewise, Mary-Jane is bound to treat Nomsa better than she might otherwise do, again because of their common church membership.

In finding a solution to her domestic servant problem, and in having a relatively happy and prosperous marriage (though there have been arguments in the past regarding Peter's association with other women), Mary-Jane is fortunate, and perhaps somewhat exceptional, among African nurses. She attributes her good fortune to the restraint imposed on behaviour by their church: she has been more forgiving than she might otherwise have been, and she feels that Peter has also behaved better than he would had he not been involved in the church. It is worth noting, in this context, that the norms, values and expectations associated with membership of Bhengu's church do not

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1 A popular women's magazine, written in English.

2 "We are all brothers and sisters in Christ" is a central tenet of Bhengu's teaching.

conflict with elite values in the way, as shown in Elizabeth's history, Catholic values may clash with those of nurses (on the issue of children and family size, for example). If anything, Bhengu's teachings reinforce elite values: Mary-Jane's knowledge, for instance, is held up as an example to the less educated women in this church. Far from being incompatible with elite values, as is membership of Zionist sects, Bhengu's teachings are such that one could perhaps anticipate an increase in the numbers of elites affiliating themselves to the Assemblies of God. In the East London congregation, according to Mary-Jane, there are a number of trained nurses. In fact, to judge from Mayer's (1963:193 - 205) account, membership of the Assemblies of God could, perhaps, be regarded as training for elite status.

It is quite obvious, from Mary-Jane's life-style, attitudes and values, that she and her family adhere to elite standards, even though she is linked, by numerous and fairly strong ties, to non-elites, both kin and fellow-worshippers. Her kin links to her siblings are reinforced by religious ties, since they all belong to the Assemblies of God. The non-elite status of the majority of Mary-Jane's siblings, is evident from their occupations. Her eldest brother farms the family land, near Ladysmith. Her next two brothers are ordinary unskilled labourers, in Durban and Johannesburg respectively. Her fourth brother runs a shop near Ladysmith. Her youngest sister failed the Junior Certificate, and is simply a housewife, married to a labourer. The sister immediately older than Mary-Jane herself, is an ex-teacher, married to a store-owner, but although this family is relatively wealthy (the "policy" of conspicuous consumption is apparent in their home), they are by no means elites. Only Mary-Jane's eldest sister, who is also a registered nurse, could be regarded as having professional status. As a point of incidental interest, these two nurses stand out, on Mary-Jane's genealogy, as having by far the

smallest living families in their large sibling unit.

Even Peter, Mary-Jane's husband, can hardly be regarded as a member of the elite. Like Elizabeth's (estranged) husband, Peter is matriculated, but without a professional qualification. He is currently employed as a sales promoter for Pro Nutro, with Hind Brothers, and he has a stable employment background. He earns R28,00 per week (R112,00 per month, gross), which is considerably more than Mary-Jane's monthly salary of R81,43 (net).

Their joint monthly income is thus approximately R185,00 net. Peter spends roughly R85,00 of his salary on rent and electricity (R10); groceries (R25); eggs (R3); marketing and meat (R30); church tithes (R11,20); and running expenses on their car (R5-10). Mary-Jane spends approximately R5,00 per month on extra groceries, pays church tithes of R8,41, pays her maid R11, and deals with the family's clothing accounts (at Universe Fashions and Smart Westons, both in Durban's West Street). At the time, the clothing accounts totalled R16,00 per month. She has finished paying off their furniture. In addition to these standard monthly expenses, Peter and Mary-Jane also have irregular educational and insurance expenditure. However, their careful budgeting allows the family to live in comfort, if not luxury. As Mary-Jane put it:

> "Even though we are poor, but still we seem to have a few cents left over each month."

While the details of their life histories vary, it may be seen that the lives and backgrounds of Elizabeth and Mary-Jane are very similar. These two nurses are fairly representative of the generation of nurses who trained in the nineteen-fifties. However, if one looks at nurses who are ten years younger, those who trained during the nineteen-sixties, a different type of background and life history tends to emerge, as is seen in the case of Pauline.

Case C. Pauline.

In many respects, Pauline's history differs from those of Elizabeth and Mary-Jane, for she belongs to a different age group, is better educated (in terms of schooling) and does not have a mission background. Pauline, aged twenty-four (born in 1946), is single, and has a town rather than a country background. She was born in Greytown, the first of six children, to literate parents. Both her Zulu father and her Coloured mother completed standard six at school. Her father is a delivery driver in Durban, while her mother used to work as a shop assistant, but is presently a housewife. With the exception of her immediately younger sister, who is a student nurse at the McCord Zulu Hospital, all of Pauline's siblings are still attending school.

Pauline herself attended the government primary and secondary schools in Greytown, as a day scholar, until she passed her Junior Certificate, at the end of 1962. She then proceeded to matriculation at boarding school in Vryheid, which had been taken over by the State administration from the Swedish Mission, under the provisions of the Bantu Education Act of 1953. A few months before she went to Vryheid, her mother and younger siblings finally joined her father in Durban, where he had been working since 1952. Pauline spent her last few school holidays in Durban.

At the end of 1964, Pauline gained passes at matriculation level in English, Afrikaans, Zulu, History, Geography and Biology. She had every intention of continuing her studies at university, but her parents could not afford to keep her at university and to educate the five younger children at least to the Junior Certificate level as well. Although she applied for one bursary, Pauline was not aware of many others, and when the university year began, she had not found the financial backing to enable her to read for the

social science degree she desired. However, she wanted a professional qualification that would give her a secure occupation even after marriage, and thus decided on nursing, which had the added advantage of pay during training, some of which could be used to assist her parents with the education of the younger children.

Pauline applied to Edendale Hospital for a vacancy, and was told that the hospital had a waiting list extending two years into the future. She then applied to Baragwanath Hospital, Johannesburg, and was accepted to begin training in April 1965. En route to Johannesburg, she shared a compartment with another Zulu girl bound for Baragwanath and nursing, and in the strangeness of Johannesburg, they were glad of each other's company.

Pauline had not expected to find a College of Nursing in a hospital. In line with the stereotype among Africans, she had regarded nursing as a practical rather than a theoretical occupation. However, the unexpected mental activity was most welcome, and Pauline did exceptionally well in her training, gaining Honours in the Preliminary Examination, and again in midwifery, which she also did at Baragwanath. She was awarded a book prize for obtaining the highest marks in her group in the Preliminary Examination, and at her graduation ceremony, was presented with another prize for her exemplary behaviour while she was living in the nurses' home.

During her training, Pauline established close friendships with Jane, a Pedi girl from Pietersburg, with whom she regularly went home to Jane's uncle's home in Molapo (Soweto) over free weekends; and Yvonne, the Zulu girl with whom she had first travelled to Johannesburg. She still maintains contact with these two friends by correspondence.

In 1967, when she turned twenty-one, Pauline's mother sent her, in addition to a gift, a cake and a silver key, and Pauline and her friends organised a party in the nurses' home, for all the students in her group. They bought cakes and cold drinks, and tea and sandwiches were organised through the nurses' home kitchen, for this party, at which the students displayed their ballroom dancing abilities[1]. The celebration of twenty-first birthdays is a relatively new phenomenon, and is not mentioned in informants' histories before the mid-nineteen-sixties.

After graduating as a general nurse in February 1969, Pauline completed midwifery and returned home to Durban, in response to her parents' wishes. Not being able to get a job at King Edward VIII Hospital, she applied to, and was accepted immediately by, McCord's. At the time of fieldwork, she was sharing a room in the nurses' home with a McCord's-trained staff nurse, who was a particular friend of one of the students in Pauline's midwifery training group, at Baragwanath. These two young staff nurses, one Zulu and one Xhosa, one trained at the premier provincial training school and the other at one of the best-known mission-type hospitals, had become great friends, and spent most of their leisure time in one another's company. Both had similar interests -- reading, ballroom dancing, going to the beach, listening to jazz and "soul" music, watching films (especially spy thrillers) and, when bored, doing handwork. Pauline also played tennis, in Johannesburg, and attended football matches as a concession to her boyfriend's interests. Fashion and dress were also important parts of Pauline's life: she was the first to introduce the new Afro wigs to the staff at McCord's, having acquired one on a weekend visit to Johannesburg, to attend a friend's wedding, in July 1970. She also

[1] A dancing instructor was employed by the nurses' home, and was constantly on hand. Most students spent much of their free time practising the steps he showed them.

attended -- but did not participate in -- beauty contests, "to have a good laugh at them parading around!"

Pauline herself is of medium height, and has a very good figure in western cultural terms. She is always exceptionally smartly dressed, whether she is in uniform, slacks, or evening dress. She uses make-up, and always wears a wig (of which she has three). Not unexpectedly, she has a boyfriend, who is eager to marry her, but she is in no hurry to get married. Her boyfriend, a Swazi, is in Johannesburg, working as a clerk. (The boyfriend she left in Durban on commencing her nursing training, was Bhaca, which seems to bear out her general feeling that nurses do not attach much importance to a man's tribal identity. She was amused, during her training, to notice how quickly rural Xhosa girls lost their scruples about going out with uncircumcised Zulu and Sutho men!)

Pauline's unwillingness to tie herself down in marriage, stems from two factors. She is keen to further her education in post-basic nursing courses, and perhaps even to go overseas; and she is worried about the instability of marriages among African nurses. She is also wary of potential mothers-in-law, for her boyfriend's mother is apparently keen that he should marry another girl with whom he has already broken up. Pauline is indignant about this on his behalf, for "she has already had her choice, when she chose her husband. She cannot expect to choose twice, for her son as well". Beneath her quiet exterior, Pauline has a decided will of her own, and she is in no hurry to acquire such a mother-in-law.

Before she left Baragwanath, Pauline asked one of the doctors to prescribe a particular brand of oral contraceptive for her, which she is

currently taking. She has no intention of bearing an illegitimate child, and also feels that she should know which brand suits her best, for future reference. If and when she does marry, she does not want more than two children, a sentiment which is shared by her room-mate.

The general pattern, as well as the details, of Pauline's background, differ from the general pattern exhibited in the histories of Elizabeth and Mary-Jane. These differences result from Pauline's age, her town upbringing, her marital status, and even changes in government policy, which have affected her educational background[1]. Of these three nurses, Pauline is the most sophisticated in terms of dress and interests (for example, in fashion and beauty contests). It is possible to regard Pauline (and others of her generation) as an example of the increasing sophistication of nurses: though unmarried, she uses modern contraceptives; she celebrated her twenty-first birthday by holding a party for her friends -- who were also nurses; her taste in literature is intellectual[2]; she is eager to travel to, and work in, other countries; and so on. She is not yet bound by the stabilising influences of marriage, home and family, as are Mary-Jane and Elizabeth.

Furthermore, it is apperent from the smaller numbers of kin appearing on her genealogy (see Case C: Pauline's Genealogy), that Pauline is not linked to non-elites to the same extent as are Elizabeth and Mary-Jane. Both of Pauline's parents are literate and are (or have been) employed in at least semi-skilled occupations. Their children will all be educated to a certain minimum level -- the Junior Certificate -- before they will be allowed to leave school. Perhaps Pauline's parents had become more aware of the value of

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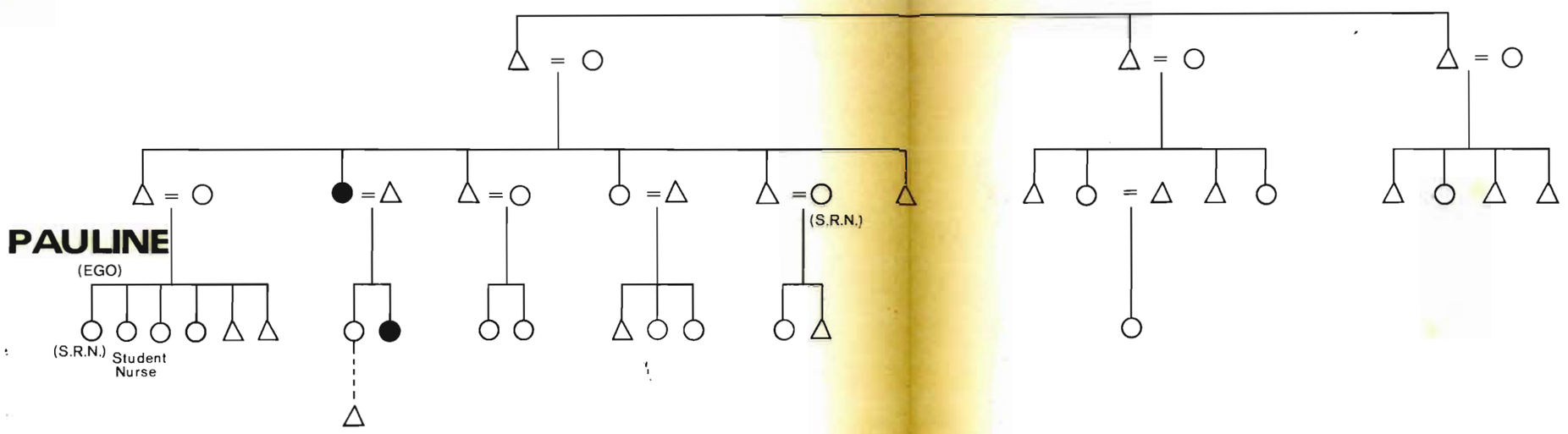
[1] Pauline's school career had only just begun when the provisions of the Bantu Education Act of 1953, were being implemented.

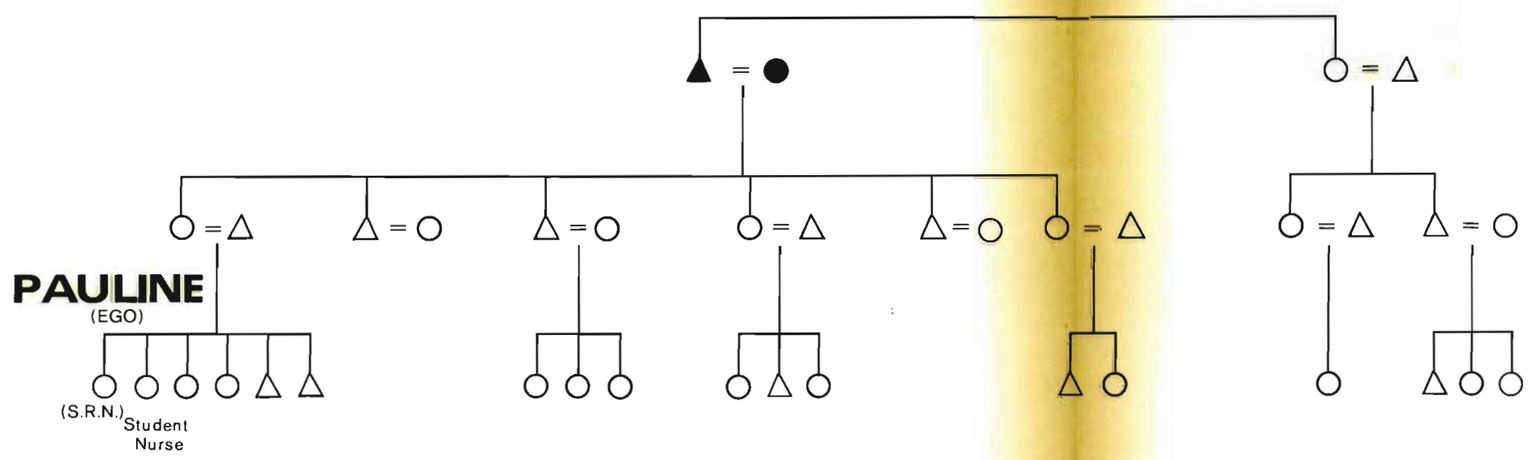
[2] At one time during the research period, she was reading a treatise on the American jury system, having borrowed the book from one of the (European) hospital doctors.



1 Patrilateral

CASE C. PAULINE'S GENEALOGY

2 Matrilateral



LEGEND:

- Male
- Female
- Deceased male
- Deceased female
- Illegitimacy

Western education to their children, as a result of their own relatively advanced education and/or their own semi-urban residence; or perhaps their occupations were sufficiently remunerative to make possible the education of all of their children.

One very important difference between Pauline, on the one hand, and Elizabeth and Mary-Jane on the other, lies in their respective educational and religious backgrounds. Both Elizabeth and Mary-Jane did their entire schooling at mission schools, and trained at hospitals in the missionary tradition, whereas Pauline was educated in a secular, government institution, and did her nursing training at a provincial hospital. Her contact with the missions has thus been minimal, yet her values and attitudes are much the same as those held by Mary-Jane and Elizabeth. In fact, Pauline is a Jehovah's Witness, as are the other members of her family. The entire family used to belong to the Anglican church, but when the African minister of the Greytown congregation was sued for adultery damages by the husband of one of his parishioners, Pauline's father removed his entire family from the Anglican church as a gesture of protest at the minister's misbehaviour. Several years later, Pauline's mother persuaded her husband to join the Jehovah's Witness sect, and again, the children (including Pauline, who was then nursing) were required to follow the lead of their father. However, Pauline does still attend Anglican services, occasionally, when she accompanies her room-mate to church. In general, however, the impression is that Pauline's commitment to her religion is less enthusiastic than that of either of the two older nurses, who have mission-oriented backgrounds. Pauline is not irreligious, but her elite status is, perhaps, tied less closely to her religious background.

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It may be seen, from the life histories of these three nurses, that the details of different nurses' lives may vary considerably. Nevertheless, the overall similarities in their attitudes, values and life style, are far more significant than the differences among them. Differences of religion, family background, age and marital status do give rise to differing interests and activities, to some extent, within the overall framework of elite identity. But while interests differ, attitudes and values are fairly constant, and I am reasonably confident that these common values are, at least partly, the result of a common socialisation process, for all nurses undergo similar, standardised training. In the following sections, then, it is necessary to examine this socialisation process in some detail.

CHAPTER NINE

ACCULTURATION AND THE POSITION OF A "MARGINAL ELITE".

Until now, I have tried to apply the elite concept, in a systematic manner, to the position of African nurses within their own African community. In so doing, for the most part I have deliberately ignored certain factors which complicate the nurses' position in the total South African society. These complicating factors, which I shall now examine, imply that my own use of the elite concept differs somewhat from the way in which this concept has been used by others, such as Lloyd and Nadel. Indeed, I believe that these factors cause African nurses (and other elite Africans in South Africa), to be categorised more accurately as "marginal elites". In order to justify my use of this apparently paradoxical term[1], I must first explain what I mean by "marginal" in this particular context.

The Concept of Sociological Marginality.

My use of the term "marginal" derives mainly from the work of Professor H. F. Dickie-Clark (1966), which deals with a Coloured community in Durban. In this work, Dickie-Clark stresses, firstly, the distinction between the so-called "marginal personality" (which is a constellation of personality traits arising from an individual's subjective definition of and reaction to his own particular situation), and the objective, sociological "marginal situation". The marginal personality is found within a marginal situation, but the marginal situation need not always give rise to such a psychological syndrome. It is possible, according to Dickie-Clark, to study

[1] Lloyd (1966:12-13) also refers to a marginal elite, in which category he includes those holders of traditional political office who have been educated in a western tradition, as well as the wealthy traders. As will become clear, my own use of the term "marginal elite" does not coincide with that of Lloyd.

a marginal situation without reference to the possible psychological effects this situation may have on certain individuals, and he emphasises (1966:3) that the marginal situation itself "does not consist of or imply any aberrant mental or emotional components". He is concerned, then, with the marginal situation solely from a sociological point of view. It is the sociological aspect of the marginal concept with which I am concerned in this chapter, too.

Dickie-Clark (1966:39) identifies "two broad categories" of matters regulated by a hierarchy, in which inconsistencies in hierarchical ranking may give rise to marginal situations:

> "...matters which belong to the cultural dimension of human interaction on the one hand, and, on the other, those which belong to the dimension of status and acceptance in a system of social relations."

In other words, he is drawing attention to the distinction[1] between culture and structure, with reference to marginal situations.

I will examine the cultural aspect first. Dickie-Clark notes that, when specific cultural attributes are (allegedly) linked to ascribed racial status by definition, any instance of substantial acculturation may result in an achieved status which is at variance with the ascribed racial role or identity. Thus, for South Africa, he notes that:

> "...the African who shares to any extent in the dominant culture is in a marginal situation." (Dickie-Clark, 1966:44).

This generalisation is perhaps somewhat sweeping, but his basic idea certainly seems to apply to African nurses, since nurses are subjected to a process of "acculturation", or "westernisation" (what I have previously referred to as "socialisation" into the medical ethos), which is certainly

[1] Noted previously: see pp. 28 - 29.

more intense and more prolonged than that of other professional groups (such as teachers), particularly among Africans in South Africa. The process of acculturation is also possibly more intense among nurses than the corresponding process is among other, more highly qualified professionals such as lawyers and doctors, because nurses are removed, physically, from the African community during their training, and their behaviour is very tightly controlled[1]. I have referred previously, in passing, to different aspects of this acculturation, or socialisation, process, but I feel that it is important to describe this process in rather more detail now, in order to emphasise the extent to which it occurs[2].

The Acculturation Process.

The student nurse is, during her training, subject to a particularly intensive socialisation process. Her life is hedged around with rules and regulations, and the life of the nurses' home is, in many respects, an extension and intensification of boarding school conditions, which most African students have experienced before beginning their nursing training. It is worth noting that the nurses' homes are usually (but not always) under the direct supervision of a senior member of the European nursing staff. Moreover, in Durban at least, because the Group Areas legislation has not yet been applied to African hospitals (which cannot easily be relocated and rebuilt in African townships), many nurses' homes attached to non-European

[1] At present, the University of Natal Medical School (which is the only medical school in South Africa exclusively for non-Europeans) provides hostel accommodation for the majority of its African students, male and female. But although they reside in these hostels for their entire, lengthy training, the control exercised over the medical students is slight, and is in no way comparable to the tight control characteristic of nurses' homes. The Medical School is also sited in an Indian/Coloured area, not a European area.

[2] The extent of this acculturation is, apparently, not accepted by certain European nurses (see the quotation from Searle, on p. 47 of this thesis).

hospitals, are located in otherwise European areas. For instance, the McCord's Nurses' Home is closely surrounded, on all sides, by European houses. Thus, even though the nurses do not necessarily interact to any greater extent with the Europeans who direct their training and control their lives while in the nurses' home, or with those who surround them residentially, the possiblity of such interaction is increased. Indeed, in such situations, Europeans may (and apparently do) become an overt reference group in terms of living standards and behaviour. Thus one of my informants (trained at McCord's) recalled, with pleasure, the comment of a friend (also trained at McCord's), made some years previously, about a photograph of herself: "Oh my! Who is that beautiful European lady?!" Such indentification with European standards (of dress, in this instance) is perhaps partly a reflection of the removal of African student nurses from African society, for a minimum period of three years.

Certainly, within the nurses' homes, and within the classrooms and wards of the hospitals, African student nurses (like their European counterparts), are constantly reminded that nurses are different from lay people in the community, and that their work is more demanding than most. In effect, the training period is the time during which the nurse is prevailed upon to accept, as morally binding, the ethics, ideals and practices of her profession -- including working overtime without pay, doing shift work and night duty, and undertaking the dirty tasks of nursing. To release the student back into the "normal" world after duty, would be to diminish her identification with hospital life, and would probably make her less willing to accept the heartaches and disadvantages peculiar to her profession: thus student nurses are required to live in nurses' homes, under the control of senior members of the nursing profession.

During this acculturation process, the African student nurse is, of course, living and working within a general system that has arisen in and is an integral part of western, industrial societies. As Kuper (1965:217) states:

> "Hospitals and clinics, the institutionalized milieu for professional employment, are part of a Western folk system of medicine. The scientific element, symbolized in microscope and laboratory, underlies the rationalization that health and life itself depend on such qualities as accuracy and hygiene."

The nurse studies intensively not only nursing procedures and techniques, but also anatomy and physiology, pharmacology and microbiology, medicine and surgery and all the other medical specialties. She is taught to recognise physiological signs and symptoms, and to relate these to one another in tentative diagnosis. She learns standard treatments for specific diseases, and also witnesses experimental changes in treatment techniques and medication. In addition to working within the germ theory framework, she is also taught how dietary deficiencies or excesses can cause or exacerbate particular diseases, and the importance of hygiene in connection with the spread of disease. All this and more she learns, seeing her increasing knowledge being put into daily application by medical and nursing staff. Most important of all, she witnesses the validity of the theory on which this practice is based, in the patients whose diseases are cured, whose chronic complaints are alleviated, whose dietary imbalances are corrected. From witnessing these successes, comes reinforcement of the new and initially alien concepts of western medical practice.

And the African nurse experiences not only the predominant success of western medicine: she also learns something of the variety of traditional

systems of belief regarding illness in different African societies. From the patients, Zulu and Xhosa, Sutho and Swazi, Pedi, Venda, Shangaan and Tswana, and from Ndebele, Shona, Tonga and others from beyond South Africa's borders, the nurse hears differing tales of disease causation and traditional treatments. Most such treatments have already failed, as is demonstrated by the patient presenting himself for "European" treatment. Indeed, some traditional beliefs are actively obstructive to the treatment ordered by the western-trained doctor, which the African nurse has learned is effective in that particular disease, and in which she believes herself.

As the nurse proceeds in her training, with such situations recurring innumerable times, her acceptance of the basis of western medicine becomes more and more firmly established, and she progresses from remembering what she has been told, parrot-fashion, to an internalised acceptance of this western system. The whole conceptual framework eventually comes to determine even her view of experiences prior to entering nursing, so that many an informant indulged in what might be termed "retrospective diagnosis" with respect to a deceased relative. "My father died in 19__. Looking back on it now, I think it must have been a coronary..." (or a stroke, or tuberculosis, or something else) was a type of comment made on several occasions by different nurses.

By the time the nurse has qualified and gained some experience, her knowledge of diagnosis and treatment is such that the newly-qualified intern has much to learn from her. Should she become a district nurse, she will, in fact, be fulfilling many of the functions of both doctor and chemist, as well as those of nurse, referring only those cases that are beyond her judgement, to a doctor.

PLATE VII.

On a darkened stage, holding lighted candles, newly-qualified registered nurses recite the Pledge of the International Council of Nurses. This photograph was taken at the 1970 Graduation Ceremony, King Edward VIII Hospital, Durban.

The very thorough acculturation process described above, is reflected in African nurses' values and life style (discussed previously), which are western-based. Of greater significance, however, than external indices such as homes and clothes, is the actual behaviour signalling these altered values. Thus in situations where one might expect, perhaps, a resort to practices based on traditional belief, among African nurses, such behaviour is conspicuous by its absence, even though it is not discounted as a theoretical possibility by nurses themselves, in response to social pressures from non-elite kin[1]. For instance, one informant described the "memorial service"[2] recently held by a teacher for her deceased husband, as being "pointless", for three reasons: "it is unnecessary expense"; "I do not believe that the dead person is in any position to be a bad omen"; and "there are other ways to honour a person's memory than by slaughtering and big parties". Finally she stated:

> "If I had my way, there would just be a small gathering of close relatives and good friends, to remember the departed soul and to pray for those left behind. But if my husband or brothers wanted me to partake in a memorial service, I would do so, not because I believe in the basic idea, but for the sake of peace, and to please them."

One might question this statement on the grounds that it deals with a hypothetical case -- what actually happens in practice? The following are some instances of actual behaviour. One informant was apparently unable to conceive. Did she then visit an inyanga? No: she herself underwent two diagnostic operations (dilatation and curettage, and a salpingogram[3]), and when no abnormality was discovered, she sent her husband to hospital for investigation. His semen analysis showed a low sperm count, and a chest X-ray revealed pulmonary tuberculosis. He was hospitalised for six months, and his wife conceived when his treatment was completed.

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[1] See Appendix IV.

[2] See Appendix V.

[3] A procedure in which air is used as a contrast medium for radiological examination of the Fallopian tubes, to test their patency.

Another informant and her husband had just completed alterations and additions to their home, raising the value of their original four-roomed township house from approximately R500 to over R2000. Did they sacrifice to their ancestors? No: they had sturdy burglar guards fitted and took out insurance to cover their furniture, and my informant told me, quite spontaneously, that others had suggested that they should beware witchcraft on the part of possibly envious neighbours, and that if they were not going to protect the house with _muti_ from an _inyanga_, then they really were running a risk by not even slaughtering a goat. She found this suggestion a rich joke.

A third informant and her husband had bought their own small car. She also laughed at the suggestion that they should throw a party to thank the ancestors, and specifically stated that their insurance policy took care of what the sacrifice theoretically should have, had they performed it. This particular informant regarded the idea of sacrifice as not only wasteful, but against Christian teaching as well, and she was the only one to add a religious element to her reasons for declining to follow traditional ways.

A fourth example concerns a nurse's infant, a few months old, who was crying and fretful for no apparent reason. Again spontaneously, she told me that, in terms of customary behaviour, she should take such a child to an _isangoma_, or an _inyanga_: instead, she had taken the child that morning to the hospital clinic, to confirm her own suspicions that the child was merely teething.

These examples show, then, that the nurses' expressed scepticism regarding traditional African beliefs, is supported by their behaviour. Nurses are aware of the expectations of African custom, and recognise these,

but they do not comply with them. Perhaps a measure of their distance from these expectations, is the fact that they can talk about them quite objectively, without a sense of "cultural shame" or even embarrassment, and quite openly. And further to this argument, they are even prepared to concede that, although they do not agree with these customs themselves, there are times when they might be in the position of participating in them, albeit peripherally, in order to satisfy the expectations of their kin.

It is my contention that the African nurse's whole attitude to African belief and custom, is shaped more by her training and role in the field of medical science, rather than by her prior missionary education or religious convictions. The acculturation process that I have described, provides the nurse with a radically new conceptual framework for identifying and treating illness, and this framework also gives her insight into the basis of western scientific thought. Her physical removal from the African community during the period of her training, thus becomes an ideological, or conceptual, separation as well. This "change from a traditional to a scientific outlook" (Horton, 1967:156) explains why the African nurse is sceptical and intolerant of traditional beliefs and practices regarding disease causation and healing in African societies. In the nurses' own words, such beliefs and practices are "unenlightened".

Indeed, Jarrett-Kerr (1960:32) notes that African nurses and doctors appear to be much more anxious than their European colleagues,

> "...to make an immediate and clean sweep of ancient tribal custom and to assert their recently acquired 'Western' knowledge".

This desire is undoubtedly related to the elites' attempts to establish new

values and alter the traditional culture to accord with their own value system. But it is more than an elite modernisation programme, for African doctors and nurses, particularly nurses, are in direct competition with persons filling traditional roles connected with healing, in African society. I am not thinking of financial competition in this context (although such financial competition does exist), but rather competition for status, influence and power. In much the same way as European doctors and nurses in White South African society frown upon chiropractors, homeopaths, and other "quacks" as a result of their competition in the field of healing, so do African doctors and nurses tend to reject the isangoma, inyanga and other roles traditionally concerned with the curing of illness.

If the argument is accepted, that the intensive period of socialisation (or acculturation) into the western medical ethos, effects the radical change in values and behaviour among African nurses, that I have tried to describe in this thesis, then the question must arise: what about the exceptions? Isolated cases are widely reputed to exist, in the African community, of a nurse, fully trained and qualified, becoming an isangoma. Apart from pleading that the exception proves the rule, how are these cases to be explained?

My informants themselves, for the most part, explained such cases in terms of mental disturbance. (In view of the multiple conflicting expectations of the African nurse, it would be interesting to ascertain what the actual incidence of mental disturbance is among them.) Another type of explanation was given by one, rather cynical nurse, who quoted me a case she had heard of, concerning a nurse who had become an isangoma and later returned to nursing. My informant explained this turn-coat behaviour in terms

of unsatisfactory financial returns, in which nursing proved to be less unsatisfactory! A third type of explanation was given by one very religious nurse, who suggested that it is the person who is poised precariously between Christianity and pagan beliefs, who is most likely to become an isangoma. My own suggestion is that, in cases where the socialisation or acculturation process has been less than complete -- for example, among nurses who start their training at a later age, and who are less flexible and receptive to the new framework -- the possibility that the individual may yield to traditional expectations, is increased. I should add that I have no objective support for any of these hypotheses, since I have not met, personally, any nurse who has become an isangoma. In any case, it would seem that the number of nurses who are reputed to have become isangoma's, is extremely small, since only two cases were actually known to my informants. It would seem that, in general, the process of socialisation into the western medical ethos is sufficiently thorough to remove the possibility that the African nurse might adopt a traditional healing role.

It would also appear that the acculturation process, with its resulting "scientific" attitude, is what makes African nurses (and doctors) clearly distinguishable within the category of elites, setting the medical and nursing professions apart from other elite occupations. The "scientific" attitude also differentiates the nurse from African women in general, and is probably responsible for much of her independent, even "feminist", attitude to "uneducated" African men.

Thus it may be seen that the nursing training, with its induction into the medical (and professional) ethos of modern, industrial societies, results in precisely that adoption of the culture of the dominant white group in South Africa, which Dickie-Clark identifies as giving rise to one type of

marginal situation. Such a marginal situation arises because this acculturation process produces inconsistencies between the nurses' ascribed (racial) and achieved (cultural) status. As a result of the acculturation process, nurses are culturally distinct from the remainder of African society (particularly non-elites). At the same time, certain structural consequences of this acculturation, in South Africa, make nurses (and other African elites) marginal to the dominant European group. Thus African elites, including nurses, are marginal within the total South African social structure.

In fact, although he recognises that cultural factors may give rise to marginal situations, Dickie-Clark (1966:185) gives precedence to the structural aspects in his definition of marginality:

> "...the marginal situation is a special case of hierarchical situations. What makes an hierarchical situation marginal in character, is any inconsistency in the ranking of the individual or collectivity in any matter regulated by the hierarchical structure...such inconsistency is the essence of the marginal situation, or what might be called sociological marginality."

The structural consequences of the acculturation process which has produced (and is producing) the marginal situation in which African nurses, in particular, find themselves, should become clear when a comparison is drawn between the role that a nurse should, theoretically, fulfil, and the role that the African nurse in South Africa is actually permitted to assume.

The Roles of "African Nurse".

The occupational role of "nurse" is that of a health specialist, whose knowledge and skills are important in the processes of maintaining and

restoring health. This role necessarily contains a marked element of authority. The sick person assumes the role of "patient" or "invalid" on condition that he submits himself to the care of recognised health specialists in order to regain his former state of health, and thus re-assume his normal roles in society. In terms of authority, then, the role of patient is subordinate to the role of nurse. Indeed, nurses are well aware of the authority they have over patients. Kuper (1965:228) quotes one African nurse as saying:

> "'Perhaps the men behave like this toward us because they are jealous, knowing that we won't marry them. <u>As patients they have to listen to us</u>.'" (My emphasis.)

Similarly, the success of the whole complex process of healing (or at least alleviating the condition of) the sick, demands that some nurses also have authority over other nurses, who are junior to them in terms of professional status. Thus the role of matron carries authority over all other nursing roles -- sister, staff nurse, student, auxiliary, and so on. At the very lowest rungs of the professional hierarchy, the ward attendant has very minimal, controlled authority over the patient, and none at all over any other grade of nursing personnel.

However, in societies such as South Africa, as Banton (1965 a:175) indicates,

> "...being White or Indian or Bantu or Negro is a role, and most other roles a man or woman assumes have to be congruent with his or her basic racial role".

Thus the African nurse enacts the role of "African", as well as the role of "nurse", and in South Africa, the ranking of authority which results from the definition of nursing roles, is at variance with the hierarchy, or system of

stratification, based on the assignment of roles in terms of racial identity.

Thus, according to the professional definition of nursing roles, the trained nurse, under the supervision of the doctor, should control the treatment of the patient, who is normally expected to follow the nurse's instructions. But in the South African situation, an African nurse (no matter what her rank in the professional hierarchy) may not treat a White patient, except in an emergency, when there is no alternative. (And in such circumstances, a report must be submitted to the South African Nursing Council, giving details of the situation.) This ruling means that, in any department of a non-European hospital where a European may have to attend for treatment on an official basis (as happens, for instance, in the Casualty and Outpatients Department at Clairwood Hospital), there must be a European sister in charge of that department. Similarly, according to the professional hierarchy, the trained, registered nurse has authority over the student, but, in South Africa, no African registered nurse may be placed in a position of authority over a White student. And again, the matron ordinarily controls all other ranks of nursing personnel, but African matrons (of whom there are by now a fair number) may not control wards that are run by White sisters: White sisters in non-European hospitals must be subject to the authority of White matrons. In all of these situations, then, it is quite clear that the basic racial role of "African" overrides the general occupational role of "nurse", and produces inconsistencies in the ranking of the African nurse, which Dickie-Clark identifies as being the core of marginal situations.

In this situation, whereby the basic racial role alters expectations of her behaviour on the part of the individual African nurse herself, as well as the expectations of other persons involved in the situation, one might perhaps expect to find altered role behaviour resulting from these altered

expectations. Thus it would not be surprising if the African nurse were to fulfil her professional role differently from the European nurse. To some extent, this idea involves Merton's (1957:423) notion of the self-fulfilling prophecy, which states that, in a given situation, because the others expect a certain type of response from an individual, they get it; and were this expectation not held, the (initially false) premise would not be rendered true in behaviour. Thus the complaints from some White nurses and some doctors of all races, that African nurses are irresponsible, incapable, and so on[1], may well be the result of some African nurses reacting in accordance with these expectations of the African nurse, who, because of her racial role, is not expected to be the equal of her European counterpart -- indeed, is expected to be different from the European nurse -- despite her identical professional qualifications.

I have shown that the basic racial role of "African" overrides the African nurse's professional status, in situations involving inter-racial contact, in the South African colour-caste hierarchy. A similar situation could be outlined for other African professionals as well. It would seem that, as Dickie-Clark has indicated with reference to Coloured people in South Africa, the composite (colour-caste) hierarchy regulates many more aspects of, for example, African nurses' lives, than does the restricted hierarchy of the profession of which they are members. Indeed, the history of legislation affecting the nursing profession in South Africa[2], provides

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[1] I must hasten to add that by no means all European nurses or all doctors hold this opinion: many explicitly reject it. However, a similar conclusion to my own on this issue, is reached by White (1966), who attributes differential stereotypes of African and European nurses, to racial prejudice on the part of those holding the stereotypes. My own research impressions suggest that these differences would appear to be largely putative, and that individuals of both racial categories may be located on a single continuum of abilities and skills, without racial clustering. I did not, however, attempt to quantify this impression.

[2] See chapter three.

graphic illustration of the processes which decreased the control of the professional nursing hierarchy over its members, while increasing the control of the composite hierarchy in this respect. The 1957 Nursing Act (As Amended) was the means by which this transfer of control, from the restricted (professional) hierarchy to the composite (racial) hierarchy, was effected. One could summarise this Act by noting that it involved a reversal of the legal integration of European, Indian, Coloured and African nurses in the nursing profession, which integration had previously existed in terms of the 1944 Nursing Act.

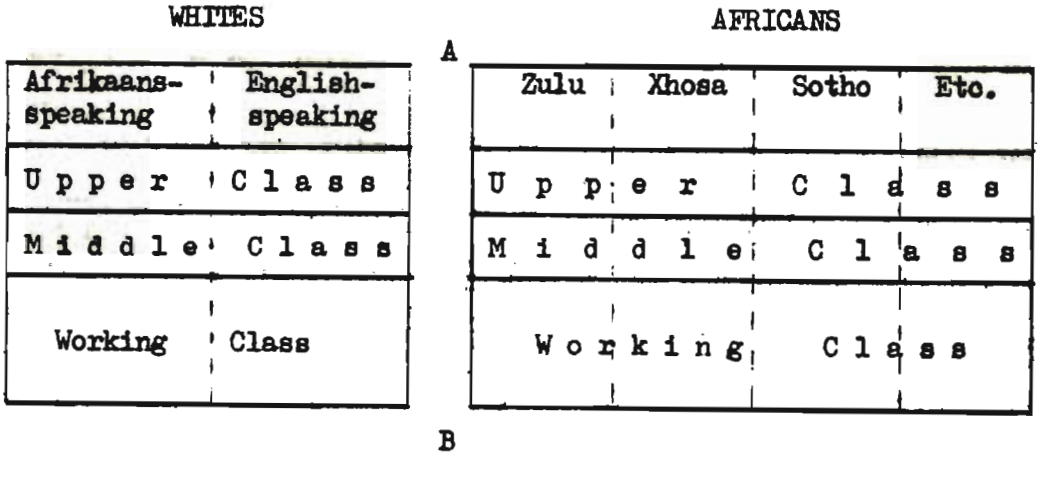
Opportunities for inconsistencies to arise in the ranking of groups or individuals for different purposes are, perhaps, increased in composite hierarchies based on ascribed characteristics such as racial identity. Such inconsistencies are, of course, based on the well-worn distinction between ascribed and achieved statuses. For when the ascribed position is defined as basic, achieved status must invariably and inevitably clash with it. It is in this context that one must view the conflicting elements in the roles of the African nurse in South Africa.

One of the reasons why inconsistencies in ranking should arise and continue to exist, is that certain inconsistencies in the position of members of subordinate strata, may actually work to the benefit of the dominant group and may, therefore, be encouraged (Dickie-Clark, 1966:37). In applying this idea to the position of African nurses, it is evident that, in terms of the policy of separate development, it is necessary to train African nurses to staff African hospitals. But, as I have shown in the previous pages, identical professional training and qualifications do not lead to full acceptance of African nurses into the system of social relations of the dominant White group in South Africa, because of their differing racial

identity. Thus African nurses are placed in a marginal situation, in structural terms, relative to the dominant stratum of South African society, while they are culturally distinct from the majority of members of their own (subordinate) racial stratum.

The Marginal Situation and Separate Development Policy.

In terms of the official policy of separate development, one should perhaps anticipate the eventual division of the nursing profession into three (or four, or perhaps eleven) sections, each distinct from the others, each with its own controlling authority. The differing "national" segments of the total society are to be compartmentalised, in the ideology of separate development, and one would expect professional bodies to be compartmentalised in similar fashion. The "multi-national" situation (in official South African terminology) has been represented diagrammatically by Banton (1967:178, figure 11: The colour line as it is envisaged in separate development), as follows:



In separate development, then, the colour bar is to swing from a horizontal position, beyond the tilted position described by Warner (Banton, 1967:144), to a vertical position. In this situation, the system of social relations within each segment is conceptualised as distinct from that of each of the other segments. Thus overall equality in the total system is defined away at

the theoretical level. Should this system come into operation, then, it seems unlikely that there would be a carry-over of the professional status of Africans into the White sector.

Jarrett-Kerr (1960:80) states that the possible division of the nursing profession was considered at the time of the 1957 Nursing Act, and that such a division (on a racial, not "national" basis, at that time) was regarded, by certain proponents of the policy of separate development, as an honest and equitable solution. But while such fragmentation of the nursing profession would possibly have removed some of the inconsistencies in the position of non-European nurses, it was not acceptable to European nurses, because of the position of the South African Nursing Association within the International Council of Nurses[1]. The South African Nursing Association had to represent the interests of all nurses in South Africa, regardless of racial identity, and the profession could not be divided on the basis of differing racial characteristics. Thus the compartmentalisation of differing segments of the nursing profession, on the basis of "nationality", has not been achieved, and it seems unlikely that such division will be achieved in the future. As I have shown in the section on the roles of the African nurse, South African society remains, at present, stratified on a horizontal basis, and the colour-caste hierarchy of the plural society is still in operation, as far as the position of African professionals is concerned. The ascribed racial role is of greater significance, in situations involving inter-racial contact, than the achieved professional role.

Thus one finds, in South Africa, the paradox of a "marginal elite", among African professionals. Nurses, and other professionally qualified Africans, are elite within one sector of the society, but they are not

[1] See chapter three, pp. 48 - 50.

recognised as having elite status in the total society. Their marginal position arises from the inconsistencies between their position as professionally-trained and qualified nurses, and the status that is assigned to them, in South Africa, on the basis of their racial identity. The marginal situation in which African nurses find themselves in South Africa, is summed up very neatly in the words of a Johannesburg delegate to the 1970 Congress:

> "We may be separated by race, but the work pulls us together."

CHAPTER TEN

CONCLUSION

In chapter two, I examined some of the arguments in favour of the use of the elite concept in discussing social stratification in Africa today, and thereafter, I attempted to present, as systematically as possible, evidence to support the contention that African registered nurses in South Africa belong to the elite stratum. In discussing why the concept of elites is particularly valuable, I gave precedence to the factor of the cultural distinctiveness of elites, as one important reason why the notion of social classes is inapplicable, at present, to African societies. There are, of course, other reasons for favouring the use of the elite concept in preference to social class.

One of these reasons concerns the dangers of attempting to apply, to African societies, stratification concepts which have been developed for western societies. Lloyd (1966:49), for instance, warns that such attempts may well result in "misleading usage of the terms or in falsification of our data". Lloyd himself rejects class analysis in favour of using the elite concept, because

> "... a social class can exist only in a system of classes. There can be no upper class without a lower class...if the African elite forms an upper class, where are the lower classes?" (Lloyd, 1966:60)

Plotnicov, however, opposes the logic of Lloyd's view with the logic of his own. He asks:

> "Is it possible that a social group -- in this case the modern African elite -- can possess all the characteristics of a

> social class and still not be considered a class because there are no other classes in the society with which it can be in political and economic competition?" (Plotnicov, 1970:270)

In part, this divergence in views would appear to be the result of differing definitions of class. Plotnicov's notion of class would appear to be Marxist in essence, for he is concerned with the competitive nature of classes and class conflict. Lloyd, on the other hand, inclines more towards Warner's idea of classes as status groups, and he rejects the Marxist concept of class completely, as far as its applicability to modern Africa is concerned.

> "Classes in the classic Marxist sense of property-owning and non-owning groups exist neither in traditional nor modern African society." (Lloyd, 1966:56)

Having rejected the Marxist idea of classes in Africa, Lloyd proceeds to reject non-Marxist classes as well, not only because of the lack of an hierarchical class system, but for the following reasons as well. Firstly, there is the lack of internal knowledge of class divisions in African societies. Social division and categorisation, as seen from within these societies, tend to run along ethnic, descent and age lines, rather than along the lines of horizontal stratification on the basis of affluence, occupation, status and so on. And secondly, he notes that, in the interests of promoting national unity in the face of tribal divisions, in newly-independent African states, a political ideology of classlessness is found, propounded by elites (Lloyd, 1966:59). Lloyd therefore opts firmly for the use of the elite concept in situations of rapid social change and mobility, such as are found in Africa today.

Most writers on the subject of social stratification in modern Africa,

would probably agree with Lloyd that a system of social classes does not exist at present. Even Tuden and Plotnicov (1970:21) concede that:

> "... until further crystallization occurs, we regard social classes as more potential than actual, more analytical than concrete categories."

But they do not agree with Lloyd's view that a single class cannot exist outside a system of classes. Tuden and Plotnicov (1970:21) regard the modern elite as "an almost fully developed social class"[1]. In so doing, they are prepared to regard the undifferentiated masses as a "residual category" (Plotnicov, 1970:300), forming the base of the stratification pyramid. I would suggest that such an analysis stretches the concept of social classes beyond its limits of usefulness. If one is going to define the lower social categories negatively, surely it is less misleading to make the negative definition explicit (as in the term "non-elites," for instance), than to talk about "residual categories" which include upwards of seventy-five per cent of the total population.

It would seem, then, that there are several reasons why the elite concept is preferable to that of social class when discussing social stratification in Africa at present. The most important of these reasons are the absence of a class system, lack of knowledge regarding class distinctions on the part of the people themselves, and the cultural differences between elites and non-elites. However, it is assumed by most authors that the elite concept will become less important in the future, as increasing economic development and modernisation give rise to a system of classes. However,

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[1] Cf. Kuper (1965:130), who states that:

> "If a society is structured on class lines, then presumably all sections are located within classes. When applied however to a society in transition, or to a plural society, there may be some value in conceiving an interim situation in which a stratum emerges from an undifferentiated urban mass and becomes conscious of itself as a class by the criteria of the dominant society."

Tuden and Plotnicov (1970:18) sound a note of caution on the possible development of a full class system in the future.

> "We must recognise that the association of social class with industrialization is a concept that derives from limited empirical instances, and that its nature is that of a hypothesis which remains to be tested. The conditions in Africa provide only part of the test."

Thus it would appear that a good deal more research and empirical data on the subject of stratification, are necessary, before stratification concepts developed with reference to western societies may be applied to African societies. As Ardener (1967:65) points out:

> "... discussions of whether there are, or not, 'social classes' in one country or another, or whether 'elites' are, or are not, turning into 'social classes' do not rest upon a firm analytical basis."

Thus there are differences of opinion between Lloyd, Nadel and others favouring the elite concept, on the one hand, and Ardener, Tuden and Plotnicov and perhaps Kuper, on the other, who regard the concept of social class as the more acceptable alternative, both now and in the future. Those favouring class analysis consider that the elite concept has outlived its usefulness. In my own study, however, I have found the elite concept of great value in detailing the position of western-educated, professionally qualified African nurses. In the context of this particular study, the elite concept has permitted the identification of particular characteristics of this specific occupational group -- characteristics which would probably have passed unremarked in an analysis of their position as members of a given social class. As shown earlier, for instance, the concept of elite status and values sheds light on the relationships of nurses to other nurses, to teachers, to their husbands, kin, servants and neighbours. It is doubtful whether class analysis

could have explained these relationships as well.

In showing why African nurses in South Africa may and should be regarded as elites, however, it should be noted that although I have analysed my data in relation to the elite framework, the research itself was not undertaken in an attempt to test the hypothesis that nurses may be regarded as elites. However, it may be seen that, in terms of the five main criteria by which elites may be identified (according to Nadel's framework), African registered nurses do have elite status.

In the first place, these nurses form a collectivity, ten thousand-strong, within which they identify with one another. This ideological corporateness may be translated into active social alignment in their friendships with other nurses, and in their membership of certain voluntary associations, including churches.

Secondly, the nurses' identity as professionally qualified Africans gives them high social status, and this high status is reflected in the reported prestige rankings of occupations. In South Africa, the nurses' status is perhaps somewhat higher than is the status of nurses in other African countries, because of the difficulty African men experience in gaining such qualifications. Indeed, in South Africa, the status differential between professional nurses and their non-professional husbands, is one source of tension in marital relationships, as the nurses themselves are well aware. The nurses' high status is also reflected in the associations to which they do belong (their professional association, orthodox churches, and particularly the Catholic Nurses' Guild. And associated with their high status in the general African community, is the fact that nurses tend to hold aloof from membership of

most voluntary associations[1].

The third main criterion of elite status -- that is, restricted admission to the elite stratum -- is also found among nurses. The nursing profession itself restricts the admission of new personnel, on the basis of professional training and qualifications. However, the restrictive influence of education is also apparent, since relatively few Africans have been educated to a level that will enable them to gain such professional qualifications. And there is a third, perhaps more subtle, restriction on admission to the nursing profession in particular, for qualified African female nurses outnumber qualified African male nurses in the ratio of approximately 100:1. Thus it may be assumed that admission to the nursing profession is also restricted on the basis of sex. But although admission to this section of the elite stratum is restricted, in the past two decades, the expansion of the nursing profession among Africans in South Africa, has been marked.

In terms of the fourth criterion of elite status, it is quite obvious that nursing qualifications and identity are achieved, not ascribed. But although the status of a "professional somebody" is achieved, this identity conflicts with the elites' ascribed racial status in South Africa.

Finally, in terms of Nadel's major criterion of "generalised superiority" in the social sphere, I have shown that African nurses are imitable. They are innovators and standard-setters, for at least part of the African population, in their life style, which includes living standards, dress, leisure activities

[1] Pauw (1963:179) notes that:

> "Without doubt the highest status is generally accorded to persons like doctors, teachers, trained ministers and nurses...there is some indication of a growing tendency among women of this level to keep somewhat aloof by not mixing on the personal level and by forming a more exclusive type of association."

and so on, and in their values. Nurses not only set an example to non-elites, they actively promote their own imitability through their personal relationships with non-elites -- kin, servants, and even neighbours.

But despite their elite status in the Black sector of South African society, I have shown that African nurses are, and will remain (at least in the foreseeable future) marginal to the system of relations involving the dominant White group. Thus their elite status is not unqualified. Moreover, the fact that these nurses are women, means that their status as elites is, perhaps, a little anomalous. As Owen (1968:72) points out with reference to western societies, few women have full-time occupations in their own right and in general, a woman's status is, to a large extent, reflected from that of her husband or father. Brandel-Syrier (1971) apparently accepts this idea, for she states (1971:xxv) that her study was concerned with "...sixty African male individuals who...constituted the entire social elite of a Bantu township on the Reef..." Thus, at the outset, she has eliminated the possibility that any women had such status. Yet later (1971:84), she states:

> "But a wife was not only an important expression of a man's status, she could also be an important status raiser. It was generally agreed in Reeftown that 'a wife can pull her husband up'. This applied particularly to those cases in which the man's education or occupation was not quite sufficient to give him upper-class status. Hence the large number of businessmen who married nurses."

Given this information, one can only ask whether it is the man or his professionally qualified wife who actually has elite status. Perhaps it would not be too far wrong to suggest that, where a non-professional man marries a professional woman, he gains the status she loses by such a marriage, and at least part of her high status comes to be regarded as his. The above quotation from Brandel-Syrier would certainly appear to lend some support to my contention that the status of nurses is considerably higher than that

of non-professional African men, despite the fact that nurses are women.

Even though my application of the elite concept to African nurses is subject to some qualifications, and even though the position of any African elite in South Africa must differ from that of elites elsewhere in Africa, it seems to me that there are many marked similarities in the life style and values of African nurses in this country and those reported to be characteristic of elites elsewhere on the continent. Indeed, some of the nurses' attitudes (for instance, those regarding contraception and family limitation) could be argued to be more elite than the corresponding attitudes of, say, West African elites, as these have been described in the literature on this subject.

Yet, as with all elites, the continuation of their present status must be uncertain. I have already shown that the nurses' elite status has been acquired largely by default, in that there have been relatively few opportunities for African men to acquire the professional qualifications which (at least in part) confer elite status. If, in the future, the opportunities for male professionals are expanded, and the normal full range of occupations emerges in each "national group" in South Africa (in accordance with separate development ideals), one would expect the prestige currently associated with the nursing profession, to decline. This long-term future possibility is, of course, associated not only with the viability of the policy of separate development, but also with economic development and the emergence of a class structure in African society (as envisaged by Plotnicov, 1970). Should this hypothetical situation come to pass, one would expect that the prestige of nursing among Africans, would decline to a level similar to that which it has among Europeans in South Africa.

Already, one could predict that, unless the salary scales for African nurses are raised and subsequently maintained at a relatively high level, the status of nurses will suffer. For one of the reasons why nursing has been such a prestigious occupation among Africans, in the past, has been that nursing salaries have been high by African standards. But the number of non-professional, white-collar jobs for Africans in South Africa, is increasing, and these occupations are, at present, more remunerative than nursing[1]. The maintenance of elite living standards requires, of course, an income substantially higher than the average.

While income is important in achieving and maintaining elite status, it is perhaps less important than occupational skills and participation in a complex, modern occupational structure. Thus as a wider range of skilled, semi-professional and professional occupations becomes available to Africans in South Africa, the special position of the nursing (and teaching) profession(s) may be expected to alter. Nurses and teachers have, in the past, enjoyed exceptionally high status, compared with the status of their counterparts in other countries, precisely because of the lack of other employment opportunities. With increasing occupational specialisation, however, one may perhaps expect to find a growing awareness of class identity and class distinctions, of a more complex order than the educated/uneducated distinction which exists at present. And in such a class structure, one may expect to find nurses occupying a lower social position than they do at present. With the development of a class structure, then, the status of African nurses as elites in South Africa, may wane and finally disappear.

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[1] At present, the starting notch on Natal Provincial scales for African registered nurses, is R840 p.a. (R70 p.m.). The starting salary for qualified African teachers is R780 p.a. (R65 p.m.). The Sunday Tribune (29 August 1971) gives the following salary scales for African posts with the Durban City Council: clerk grade II, R146-R152 p.m.; truck driver, R90-R105 p.m.; health inspector, R119-R224 p.m.; health visitor, R112-R147 p.m.; traffic constable, R65 p.m. fixed. The highest salary an African university professor may be paid at present is R5 520 p.a. (R460 p.m.).

APPENDIX I

QUESTIONNAIRE[1]

If any question does not apply to you, please put N/A (Not Applicable) next to it.

1. In which year were you born? . . . . . .

2. What was the highest standard that you passed at school? . . . . . .

3. What church do you belong to? . . . . . .

4. What is your marital status? (Please indicate the correct category by X.)
   single . . . . . .
   married . . . . . .
   separated . . . . . .
   divorced . . . . . .
   widowed . . . . . .
   (remarried) . . . . . .

5. How much lobola was given when you were married? (Approximately) . . . . . .

6. In which year did you get married? . . . . . .

7. How many children do you have? . . . . . .

8. What was the highest standard that your husband passed at school? . . . . . .

9. What is your husband's work? . . . . . .

10. Have you ever lived apart from your husband since getting married (e.g. in a Nurses' Home)? . . . . . .
    If so, for how long did you live apart? . . . . . .

11. Please list all of the hospitals, clinics, etc., at which you have worked, including your training hospital(s). . . . . .

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[1] This questionnaire was distributed to 930 African registered nurses, of whom 226 returned completed schedules. The accompanying letter explained the purpose of the research, and emphasised that identification was not required, and that information would be kept confidential.

APPENDIX II

COMPARATIVE FIGURES FOR CERTAIN OCCUPATIONAL CATEGORIES.

The following figures were derived from the 1960 Census, and have been abstracted from 1970 South African Statistics, compiled by the Department of Statistics, Pretoria, and published by the Government of the Republic of South Africa.

AFRICAN MALES	OCCUPATIONAL CATEGORY	AFRICAN FEMALES
23 000	A.Total professional, technical & related.	25 487
2	Architect	-
19	Engineer	1
11	Surveyor	1
1	Chemist/Physicist	-
23	Vetenarian/Biologist	3
83	Medical Practitioner/ Dentist	24
1 127	Nurse/Midwife/Nursing Aid	12 786
87	Medical Auxiliary	16
2 852	Other medical Services	296
11 871	Professor, Teacher, etc.	11 585
35	Jurist	-
242	Draughtsman/Technician	13
11	Chartered Accountant	-
6 634	Other professional	759
5 458	B.Administrative, Executive & Managerial: total.	285
18 276	C.Clerical: total.	1 000
25 522	D.Salesworker: total.	3 372

Unfortunately, figures from the 1970 Census (for occupational categories) are not yet available. However, since 1960, the number of African registered nurses alone has doubled, and attention has been paid to producing more female than male teachers. One could expect, then, that the 1970 Census figures will probably show that the gap between male and female African professional workers, is widening in favour of African women.

APPENDIX III

PROCEDURE ADOPTED FOR THE OGWINI BRANCH.

A. NAME AND OBJECTS.

1. That the Branch shall be called Ogwini Branch of the South African Nursing Association.

2. That the objects of the Branch shall be

   (a) To raise the status, maintain the integrity, and promote the interest, and open up opportunities for study and service of the Nursing and midwifery professions.

   (b) To consider and deal with any matter affecting Nurses or Midwives or student nurses or pupil midwives.

B. COMPOSITION.

3. That all trained Nursing and Midwifery persons as well as Nursing and Midwifery students, and enrolled Auxiliary Nurses of African descent falling within the region of the Ogwini Branch of the S. A. Nursing Association, shall automatically become members with due subscriptions paid.

C. CONTROL.

4. The Headquarters of the Branch shall be King Edward VIII Hospital.

5. That the Headquarters of the Branch shall have meetings held not less than four (4) times a year i.e. every three months.

6. That the meetings during other months will rotate in order to arouse interest in the various institutions within the region.

7. The affairs of the Branch shall be controlled by an Executive Committee consisting of eleven members, four of whom shall be office bearers -- that is:-

   (a) (i) Chairman
   (ii) Vice-Chairman
   (iii) Secretary
   (iv) Assistant Secretary.

   (b) Members shall hold office not more than three years in succession, but one shall be entitled to belong to the Executive Committee as long as he or she is elected as such.

   (c) Any member of the Executive or other office bearers shall be eligible for re-election.

   Elections for office bearers and for Executive Committee shall be held once every year in April.

CLASSIFICATION OF MEMBERSHIP.

8. Members shall be divided into the following classes:-

(a) Full members: These shall be state registered Nurses and Midwives.

(b) Junior Members: These shall be State Student Nurses.

(c) Associate Members: These shall be Enrolled Auxiliary Nurses.

MEETINGS.

9. PROCEDURE: Before each meeting the Agenda shall be circulated to the Local Representative at most, 14 days prior to the meeting.

10. Accurate minutes of meetings shall be kept by the Secretary and shall be available to members of the Branch on request.

11. The Branch shall further decide upon its rules or procedures subject to the standing rules and orders, appended hereto.

12. (a) The Executive Committee shall consist of eleven members.
(b) The Quoram (sic) of the Executive Committee shall consist of five Executive members.

13. Besides the quarterly Executive meetings held at the Headquarters seven days before the quarterly general meeting, there shall be other Executive meetings in between.

14. Besides deciding its own rules of procedure, the Executive shall deal with urgent matters and shall also carry the resolutions of S. A. Nursing Association in consultation with the Branch.

15. Accurate minutes of the Executive shall be kept by the Secretary. Where a centre is not represented on the Executive, it shall be invited to send an observer to all Executive meetings.

16. PROCEDURE: Proposals by members of the Executive, when the Executive is not meeting, shall be forwarded to the Secretary, who will lay them before all members of the Executive by post.

17. Each institution or establishment shall form its own sub-committee to advise the people of the proceedings of the previous meeting. Such Sub-Committee shall be responsible for collecting dues and subscriptions in their respective institution, and establishments and shall forward such collections to the forth coming meeting.

18. Non attendance by an Executive or Office Bearers at three consecutive Executive Meetings without prior notification of the Secretary shall mean automatic ceasation (sic) of such member as an executive member. His or her place shall be filled by co-option by the Executive until the following General elections.

19. Elections for Office Bearers and for Executive Committee shall be held once every year in April.

20. VOTING POWERS.

(a) That only full members shall vote at all general meetings.

(b) Only the Chairman shall have the right to cast a vote (sic).

21. There shall be subscriptions to the Branch of 30 cents half yearly or 60 cents yearly.

22. The Finances of the Branch shall be kept in a Building Society Account. Withdrawals shall be signed by three members: the Chairman, the Secretary and the member of the Committee appointed by the Committee.

23. Amendment of Procedure Adopted for the Ogwini Branch.

(a) Any amendment or Additions to this Procedure shall be passed and become effective if carried by a 2/3rd majority vote of members at an Annual General Meeting,

(b) All proposed Amendments shall be published three weeks prior to the Annual General Meeting at which they are to be considered.

24. Ceasation (sic) of Membership.

Any member may be deprived of his/her membership, if he/she is deemed by a 2/3rd majority of the delegates at a meeting, to have acted in a manner detrimental to the interest of the Branch. Such person must receive adequate opportunity of presenting him/herself before the meeting.

* * * * * * * * * * *

The constitution of the Ogwini Branch has been reproduced here without alteration or correction.

APPENDIX IV

A FICTIONAL EXAMPLE OF CONFLICT BETWEEN ELITE AND TRADITIONAL VALUES

One of my informants wrote a short story, which appeared in serial form over a number of weeks in 1970, in the Catholic weekly publication umAfrika. This story concerns a young rural Christian man, who goes to town to work as a clerk. He meets and marries a staff nurse, and insists that his wife stay with his parents in the country, against her wishes.

Although they wish to have children, the wife does not conceive. She consults a doctor and undergoes thorough medical examination, and the doctor states that there is no physical reason why she should not conceive. Her parents-in-law, with whom she is living, then insist that she visit an inyanga. At first she is horrified, but eventually she accedes to their demands and visits the inyanga, with her mother-in-law.

The husband learns about this visit to the inyanga when he comes home for a weekend visit, and, being a good Christian, he is so angry that he refuses to allow his wife to stay with his parents any longer. They return to town together, and establish their own home. Psychologically at ease for the first time in her marriage, and removed from the tensions of living with affines, the wife conceives. Here the story ends.

If one assumes that one of the ways in which norms and values percolate through a community, is by means of news and other mass media of communication, this simple story is highly significant, for it is putting forward not only new behaviour patterns, but reasons for these. It is perhaps another instance

of the ways in which nurses may promote their own imitability, this time by means of the written word rather than through interpersonal relationships. It also illustrates the conflict of values between nurses and their husbands, in the initial instance, and their senior affines particularly. It also validates the breach of relations with the senior generation, for once they are settled in their own home, as the nurse initially wanted, they are rewarded with children. The choice of a nurse as the heroine who is proved right is also significant, though perhaps inevitable since the story was written by a nurse.

APPENDIX V.

THE MEMORIAL SERVICE: A SYNCRETIC RITE.

In May 1969, two newspaper reporters were killed in a motor accident *en route* to the funeral of Cyprian, Paramount Chief of the Zulus, at Nongoma. The car in which they were travelling left the road and plunged down a cliff not far from Nongoma. One of these reporters, Fred M____, who had been on the staff of *Ilanga lase Natal*, was buried on the mission at Mariannhill. He was approximately thirty-six years of age when he died, and his widow, an infant school teacher, was responsible for the events described below[1].

Fred M____ was buried at Mariannhill some five or six days after his death. The Catholic funeral service in the early afternoon was followed by the slaughtering of a goat immediately afterwards, all of which was consumed by the mourners that evening. The goat, which was slaughtered by friends and kin of the deceased, was purchased by his widow.

One year later, in May 1970, printed invitations, some in Zulu and some in English, were distributed by the widow:

> "You are invited to attend the unveiling of the tombstone for Mr. M____, on Saturday, May ___. Requiem Mass at 9.30 am. Luncheon at 12.30 pm."

In fact, the memorial service proceedings started on the Friday evening. At 4.30 pm, a goat, purchased by the widow, was slaughtered by friends and relatives. All of the blood from this goat was collected, and to the blood was added a certain type of veld grass which, at the time, was seeding

[1] I am indebted to Mrs. L. Gumede for the account of the proceedings which is produced here.

(isiqunga), and a dark powder, bought from an inyanga. This mixture was boiled, and eaten by everyone present. The eating of the treated and cooked goat's blood was explicitly stated to be a cleansing or purification rite, and the preparation of this muti was undertaken only after the widow had washed her hands very thoroughly, as a preliminary purification measure. All of the goat's blood and the meat was consumed at the widow's home on the Friday night, and this was regarded as essential, though my informant was unable to discover the reason for this.

At the same time as the goat was killed, an ox (which had cost the widow approximately R60) was also slaughtered, and was hung up on poles for the blood to drain out of the carcase. What happened to this blood is not known, but it was definitely not used in the same manner as the goat's blood.

Early on the Saturday morning, the local women (not all of whom were related to the widow) began cooking the beef. The beef from the slaughtered beast was supplemented by more bought directly from the butcher, which was used only for stewing. Of the women undertaking the preparation and cooking of the meat, only the deceased's mother and her two sisters were his kin: all the rest were lady teachers from the mission, most of whom were preparing cold meats and salads for the luncheon. No chickens were used at all for this luncheon, or at any other time during the proceedings, and my informant suggested that the reason for this might be that the slaughtering of chickens is associated with Zionist sects.

Although the total number of people invited is not known, some sixty people actually attended the memorial service and luncheon, including the widow, the deceased's mother and her two sisters, the widow's siblings and families.

The Requiem Mass was conducted by an African Catholic priest who did not belong to the Mariannhill diocese, but who was asked to conduct the service because he was a friend of the family of the dead man. He was assisted by two European priests. From the cathedral, the congregation proceeded to the graveyard across the road, where prayers were offered and the tombstone was unveiled. Before dispersing, each person who had attended the service, regardless of religious affiliation, sprinkled Holy Water on the tombstone, following the example of the officiating priest. The whole service lasted approximately one hour.

From the graveyard, proceedings moved to the widow's house, where luncheon was served. The meal consisted of rice and the stewed beef bought from the butcher, other vegetables, cold meats and salads, puddings, cakes and cold drinks. When this luncheon was completely finished, the meat from the slaughtered ox was served, together with beer brewed some days previously by the widow and her friends. The beer was brewed in clay pots and tins.

Friends from the mission and surrounding areas began dispersing in the afternoon, but relatives who had come from further afield to attend the ceremony, did not start leaving until the evening, after the widow had distributed the deceased's belongings. Since their son was only five years old, she kept very little -- a couple of his suits, and his books. Most of his clothes were given to mentally-retarded men from the mission. Very few of his possessions went to his kin.

* * * * * * * *

In terms of elite values and behaviour, it is perhaps significant that no nurses attended this memorial service, although some were invited. Teachers, on the other hand, not only attended, but actively assisted in the preparations.

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A MARGINAL ELITE?

A STUDY OF AFRICAN REGISTERED NURSES IN THE GREATER DURBAN AREA.

by

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B. Soc. Sc. Hons. (Natal)

Submitted in partial fulfilment of the requirements for the degree of Master of Social Science in the Department of African Studies, University of Natal.

Durban, 1972.

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ACKNOWLEDGEMENTS

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Finally, I must acknowledge the financial assistance of the Human Sciences Research Council (of South Africa), in the form of a bursary to read for a Master's degree. The opinions expressed and conclusions reached in this thesis, however, are mine alone, and must not be regarded as a reflection of the opinions and conclusions of the Human Sciences Research Council. Similarly, I must assume full responsibility for any errors in fact or in interpretation, which may be present in this dissertation.

INTRODUCTION

> "The development of an African class structure has been mentioned by many writers on modern Africa, but it has not been shown that a true class structure has as yet developed. In fact, we know little about forms of social stratification, whether in Africa or in the remainder of the non-western world." (Middleton, 1970:255)

Although there exists a vast body of literature on forms of social stratification in Europe and, more particularly, North America, there are relatively few such studies pertaining to Africa. The minimal information regarding social stratification in urban areas in Africa, appears to have resulted from the selective interests of anthropologists, who have concentrated on the assimilation of individuals into town life, the processes of urbanisation, rather than the study of the already urbanised and the actual dynamics of urbanism[1]. Stratification concepts such as "class" and "elites" have thus tended to be used with little explicit discussion of their implications, applicability, or even usefulness in the African situation. One can, of course, glean something from such writers as Chodak (1966) and Worsley (1969), who have recently taken critical looks at the class concept with reference to developing countries, and the collection of papers in Tuden and Plotnicov (1970) is a welcome addition to the literature on the subject of social stratification in Africa. The 1956 special edition of the International Social Science Bulletin, together with the collection of papers in Lloyd (1966), represent significant, if pioneering, attempts to refine the concept of social elites for anthropological and sociological usage. In these latter two volumes, however, only Nadel (1956) and Southall (1966) have examined some theoretical aspects of the elite concept.

Middleton (1970:256) comments further that "Studies of elites are

[1] I am using this term in the sense in which Wirth used it, to refer to an "urban way of life".

relatively few". The most recent publications dealing with elites are those of Lloyd (1967 a and b; 1968), Jacobson (1968), Plotnicov (1970), Mair (1971) and Brandel-Syrier (1971). Studies dealing specifically with female elites are virtually non-existent, which fact may reflect the absence of any female elite to be studied. Leith-Ross, for instance, concluded that, at the time of writing (1956), there existed no "feminine elite" in Nigeria, although a tiny number of women might have qualified, individually, for elite status. Fifteen years later, this time with reference to South Africa, Brandel-Syrier (1971:xxv) implies a similar situation when she states that her study concerns "...sixty African male individuals who...constituted the entire social elite of a Bantu township on the Reef..." (In fact, as I shall attempt to show later, Brandel-Syrier's own data would appear to indicate that, of these elites, some were not the men themselves, but their wives.)

In this situation, my own study is intended as a contribution, however small, to the very scanty literature on female elites in Africa; and it also attempts to examine some previously neglected aspects of the elite concept in the light of the contemporary South African situation. It does so by applying the elite concept, as this concept has been developed by Nadel (1956) and others, to a particular category of African professional women who, on the basis of my own and other evidence (for example, that of Kuper, 1965), should be regarded as elites in their own right, rather than as (educated) women deriving high status from their elite husbands.

At the outset, it should be stated that my study represents an "internal view". That is, it is concerned with the light in which African nurses see themselves, rather than with a consideration of how other Africans assess the nurses. Thus I am concerned with the nurses' own self-image, rather than with the community image of African nurses. This concern is, in

one sense, deliberate, since my research was restricted to members of the nursing profession. Nevertheless, it is regretted that resources of time and money did not allow the full-scale community survey which would have been necessary in order to gain a reliable picture of community attitudes towards nurses. However, there does exist some rough guide to community attitudes, in the study of prestige rankings of various occupations, reported by Kuper (1965:436). In this study, the least educated group (primary school children in standard five) ranked the nurse in fourth position on the scale, higher than her sixth ranking by the other three, more educated groups. (The scale included female occupations, but the majority of the occupations, while they could be filled either by males or by females, were predominantly male jobs.)

In view of my lack of data regarding the nurses' position in African society in general, from the points of view of non-nurses and non-elites, I am not really concerned with the wider field of social stratification, except indirectly. This thesis is rather a consideration of why African nurses in South Africa, should be regarded as elites in their own right, on the basis of their professional occupation, corporateness, high status, imitability and general life style, including their attitudes, values and behaviour. The elite status of African nurses in this country has been implied or even explicitly mentioned in some existing literature[1], but nowhere has their position been examined in detail in relation to the elite concept.

The existing data which form the basis for regarding nurses as elites, are qualitative rather than quantitative, as are my own data. Of the general field of one-thousand-odd African registered[2] nurses working in the Durban area, to the majority of whom a very short questionnaire was distributed[3],

[1] See Brandel (1958), Brandel-Syrier (1962, 1971); Wilson and Mafeje (1963); Kuper (1965); Vilakazi (1965); White (1966).

[2] This category excludes students, auxiliaries and nurse aides.

[3] See Appendix I; and chapter one for details of the distribution of this questionnaire.

less than one hundred and forty were employed at the three hospitals in the Durban area, at which my research was conducted. At the McCord Zulu Hospital, Clairwood Hospital, and St. Mary's Hospital (Mariannhill), I interviewed as many registered nurses as possible, during their off-duty hours, lunch-hours and even tea-times, individually and in groups of varying sizes. The interviews were usually conducted in hospital tea lounges; sometimes in the visitors' lounges of the nurses' homes; and, wherever possible, the interview situation was extended beyond the hospital to the homes of married nurses in the townships (Umlazi, Lamontville and Kwa Mashu) and on the mission station at Mariannhill. (See Map A.)

Interviewing was the main research technique on which this study depended, but direct observation was also possible, particularly in the hospitals. Wherever possible, I attended hospital functions, which included a graduation ceremony, an exhibition of handwork, chapel services, sporting activities, nativity plays and dances. In addition, nearly four weeks were spent observing what occurred in the wards and clinics of McCord's and St. Mary's hospitals and, later, the Charles Johnson Memorial Hospital at Nqutu (Zululand). Although official permission for me to undertake ward observation in the hospitals controlled by the Natal Provincial Administration, was refused, I was shown over Clairwood Hospital when I began research among the nursing staff working there. Thus I came to know fairly well the working situation in which nurses spend nearly one-quarter of their lives as workers. The hospital situation, of course, constitutes an extremely important aspect of nurses' lives, and may be regarded as a "social field" in itself: I did not explore this avenue of research in any detail, however.

I was also able to observe a second facet of nurses' professional lives, by attending meetings of the local (African) branch of the South African Nursing Association, the Ogwini Branch. Fortuitously, too, the

seventh biennial congress (for African members) of the South African Nursing Association, was held in 1970, at the University of Natal Medical School, in Durban. At this congress, I had the opportunity of meeting and talking to African nurses from many different parts of South Africa, who were employed in many different nursing fields.

In addition to the extensive data gained from interaction and discussion with this wide range of informants in professional situations, I collected intensive, detailed life history material from a core of some twelve informants. The total interviewing time spent with each of these informants was in no case less than ten hours, and in one case totalled well over sixty hours. Interesting points often arose in non-interview situations as well, such as visits to market, shopping expeditions, visits to children at boarding school, and while giving "lifts" to nurses on innumerable occasions.

One major gap in my data should be noted, however. I gained very little first-hand information on husband-wife and husband-family relationships, since I was permitted to enter African townships only during normal office hours, when my informants' husbands were, of course, away at work. The data that I do have on family relationships were collected among families residing on mission territory and may, perhaps, be atypical of the family situation of African nurses living in the townships: I have no way of knowing. Particularly in the field of marital and family relationships, then, does my material reflect the "internal view" mentioned above, and the one-sidedness of the resulting picture must be recognised.

In addition to ethnographic data, I have also made use of other material, published and unpublished, which relates to the position of African nurses in South Africa. Legislative and historical material, in particular, has direct relevance to any consideration of the position of nurses as elites.

Hence I do not apologise for the inclusion of material which could, perhaps, be regarded as non-anthropological.

Finally, it should be noted that the present tense used in this dissertation, refers to the situation as I found it to be in Durban in 1970. The Durban situation probably does differ slightly from conditions in other centres, as a result of relatively minor variations in socio-economic factors. However, I have no reason to think that the social position of African nurses in the Durban area differs radically from, or is atypical of, their position elsewhere in South Africa. Local variations in socio-economic conditions and opportunities may affect the structure of the local elite in individual areas and communities, but the general composition of the overall elite stratum in any one country, would seem to be fairly constant. Thus the conclusions reached in this study could probably be applied in South African towns and cities other than Durban, since I have dealt with nurses as part of the overall elite, rather than dealing, as Brandel-Syrier (1971) did, with a particular local elite.

FIELD OF STUDY AND METHODS OF RESEARCH

As I have already mentioned in the introduction, the study on which this thesis is based, involved African registered nurses working in the greater Durban area. The study did not focus on any definable community, for my informants were drawn from three different hospitals in the Durban area (plus one in Zululand, for comparative purposes), and lived in three different townships (Umlazi, Lamontville and Kwa Mashu), in nurses' residences at the hospitals, and on mission territory. Of the total field of approximately one thousand registered nurses working in the Durban area, less than one hundred and forty were included in the reduced field of the three hospitals chosen.

Definition of the Field of Research.

Nursing personnel in South Africa may be grouped into four categories: ward attendants or nurse aides; student nurses; enrolled auxiliary nurses; and registered nurses.

Ward attendants and nurse aides are completely untrained, although they may have gained experience in previous hospital work. Basically, they undertake domestic duties, but they may be required to assist with certain unskilled nursing tasks in the hospital wards. Nurse aides are not subject to the control of the official body governing the nursing profession in South Africa, the South African Nursing Council. In effect, although these aides may sometimes be regarded by the uninformed public as nursing personnel, they are not really part of the profession.

Student nurses may fall into one of two categories, depending on

whether they are training to become auxiliary or registered nurses. Both categories of students are under the control of the South African Nursing Council, and both follow prescribed, standardised courses of training. The general training leading to registration extends over a minimum period of three years, however, and leads to a qualification which is recognised internationally; whereas the auxiliary training is shorter in time, and is geared to providing a supplementary source of nursing personnel to assist the registered nurse, freeing her from routine, semi-skilled nursing tasks so that she may use her specialised knowledge and administrative skills efficiently. The auxiliary training equips the nurse to undertake practical nursing duties, rather than providing her with the detailed theoretical knowledge of anatomy and physiology, pharmacology and microbiology, and medical and surgical specialties with which the general training is concerned.

Enrolled auxiliary nurses, once qualified, may work anywhere within South Africa, but their professional certificate is not recognised in other countries. In fact, the auxiliary certificate has been recognised between different provinces in South Africa only since 1957, when responsibility for this category of nurse passed from the provincial hospitals to the South African Nursing Council, under certain provisions of the Nursing Amendment Act. Because the auxiliary course requires a lower educational standard for admission to training, and because it is of shorter duration than the general nursing course, it has become increasingly important among Africans, but very few White South Africans become enrolled auxiliary nurses. In the words of the South African Nursing Association, auxiliary nurses are "associate members" of the nursing profession in South Africa, and do not have voting rights, at present, on issues concerning the profession.

I chose to restrict the scope of this enquiry to "full members" of the

nursing profession -- to those women who have a minimum qualification of registration as a trained general nurse with the South African Nursing Council. Of over 10 000[1] such African women in South Africa at present, some ten per cent of these are working in the Durban area. In limiting my interest to this category, I have ignored all of the other three categories discussed above, as well as male nurses, of whom there are insignificant numbers. Hence, unless it is explicitly stated otherwise, by the term "nurse", in the remainder of this thesis, I refer to trained, registered, female general nurses.

In view of my limited resources of time and money[2] for this study, student nurses were excluded from consideration because of the possibility that their training might be abandoned before completion, in which case their "junior membership" of the nursing profession is terminated without being replaced by any other type of membership. A fully qualified and registered nurse, however, is recognised as such even if she is not practising as a nurse. Auxiliary nurses were excluded because the qualitatively different training produces a nurse recognisably different from the general nurse. This difference, particularly with reference to Africans, was regarded as being sufficiently important to warrant a full comparative study, which would have been too ambitious for my purposes.

As far as health institutions employing African registered nurses are concerned, there are some twenty-odd hospitals, clinics and tuberculosis settlements for non-Europeans in the greater Durban area. In addition, there are a few non-European doctors in private practice, who employ surgery nurses. I decided to concentrate on the hospitals, since these are the best-known type of health institution. Of the eleven hospitals in the Durban area,

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[1] 9 112 as at 31 December 1969: figures supplied by the S.A.N.C.

[2] My bursary was worth R500,00, for one year only.

the McCord Zulu Hospital was selected for primary emphasis, since it is relatively small and easily accessible.

An original supposition had been that nurses trained in different hospitals might display significant differences in attitudes, behaviour and life styles, depending on the type of hospital at which they had trained. Hence a comparative study of a private hospital (McCord's), a provincial hospital (King Edward VIII) and a mission hospital (St. Mary's, Mariannhill), was originally envisaged. However, it became apparent very soon after the research was begun, that this hypothesis did not take into account the factor of mobility among African nurses. The importance of this mobility factor may be judged from table 1[1].

TABLE 1. Number of hospitals at which African registered nurses have worked, including training hospitals, according to age category.

Age Category	Number of Hospitals									
	1	2	3	4	5	6	7	8	9	Total
Under 30	12	16	14	11	4	2	2	-	-	61
30 - 40	17	17	22	22	23	3	1	2	1	108
40 - 50	1	3	10	13	5	9	7	1	-	49
Over 50	-	-	-	-	2	2	1	2	1	8
Total:	30	36	46	46	34	16	11	5	2	226

While it is obvious that the age factor is important when considering mobility among African nurses, it may be seen that a very small proportion (13,3%) of the total number, have worked at only one institution.

Faced with this situation, and with research difficulties at the King Edward VIII Hospital, it seemed logical, at the time, to shift the emphasis of the research to different age categories among the nurses themselves, who

[1] The figures used in table 1 come from a questionnaire used in the course of the research, which will be discussed later in this chapter.

were drawn from different hospitals, namely McCord's, St. Mary's and Clairwood. Aside from differing leisure-time interests and activities, however, remarkably few differences were to be found in attitudes and outlook among nurses of differing ages. It appeared, in the final stages of research in Durban, that the common nursing training imbued nurses from different cultural backgrounds and different age groups, with common ideas and attitudes: in other words, that their identities as nurses were of prime significance, regardless of other factors.

When research in Durban had been completed, I spent some weeks at the Charles Johnson Memorial Hospital at Nqutu, in Zululand, in an attempt to discover whether there exist any significant differences between nurses in town and those in country areas. Not unexpectedly, I found a rather quicker rate of staff turnover at this mission hospital than was found at any of the Durban hospitals studied[1]. A small minority of registered nurses working at the Charles Johnson Memorial Hospital say that they prefer to live in the country, away from the violence and insecurity of township life, but in other respects, I found no differences between country-oriented and town-oriented nurses. Indeed, African nurses themselves say that any differences there may be originally between students from rural, as opposed to urban homes, are usually eliminated by the end of the training period. The rural-urban distinction, and the distinctions based on tribal identity and language, are initial divisive factors that become less and less significant as the students proceed through their training.

Since there are few differences (none of which appear to be significant) based on different training hospitals, age, or town as opposed to rural

[1] Isolated country hospitals, lacking both adequate working and social facilities in most cases, are used by African nurses as "stop-gaps", which afford them temporary employment while they await vacancies at the bigger urban hospitals. C.J.M.H. has better facilities than many country hospitals and, therefore, probably has a lower rate of staff turnover than most others.

background among African registered nurses, it would appear that their identity as educated, professional nurses is so important that it overrides these other (potential) distinctions. Thus the focus of this study finally came to rest on the social identity of African nurses as elites.

The Fieldwork Scene.

Although this study did not involve any particular community (except, perhaps, the "professional community" of nurses), a hospital is, or can be, a relatively self-contained community in itself, particularly if it is geographically isolated. Even in large cities and towns, however, a hospital may be regarded as a distinct social field, with possibly unique characteristics. The nurses I studied spent roughly one-quarter of their total time[1] actually working in the hospitals. Some of their off-duty hours were also spent at the hospitals (for instance, on days when they worked split shifts with a couple of hours off in the afternoon). Some, of course, actually lived at the hospitals, in the nurses' residences. The hospitals obviously constitute a significant aspect of the nurses' total lives, for not only is the hospital the work-place, it is also the focus of their identity as nurses. A short discussion of some of the identifying characteristics of the hospitals at which I did a large proportion of my research, is thus important. (See map A for the localities of these hospitals.)

(a) McCord Zulu Hospital.

The Mission Nursing Home (as it was first called) was opened in 1909,

[1] Nurses officially work a forty-hour week, and there are one hundred and sixty-eight (168) hours in each week. Thus, apart from her annual leave, the nurse is occupied, for approximately one-quarter of the hours in each week, in her hospital job.

after a lengthy legal battle, which ended in the Supreme Court of Natal, had finally overcome opposition to the building of a non-European hospital on Durban's Berea ridge[1]. The twelve-bed hospital was the personal financial liability of Dr. James McCord, an American missionary doctor, and it was the first hospital in Durban to cater exclusively for the needs of the African population. From the start, it was intended to serve the Zulu people from all over Natal and Zululand, and one aspect of its service role was the training of African personnel in aspects of western medicine. Although plans for the training of medical aides, and later, doctors, were largely unsuccessful, the training of nurses began immediately, though not without difficulty.

> "To find even three Zulu girls willing to study nursing had been difficult enough, for none in all South Africa had ever trained for that career before. They were as wary as their parents of any path not worn deeply by other native feet." (McCord and Douglas, 1951:181)[2].

Nursing training began in 1910, but until 1924, when the bed capacity had been increased and other facilities improved, it was not recognised as being of sufficiently high standard to enable the nurses to become registered with the Colonial Medical Council. Midwifery training was also commenced in the early nineteen-twenties, and the Mission Nursing Home had the distinction, in 1927, of producing the first doubly-qualified African nurse (in general nursing and midwifery), in South Africa.

The World Depression of 1929-32 affected the hospital drastically, since the American Board of Missions (which had taken over the hospital in the early nineteen-twenties), could no longer support it financially. In 1931, a Hospital Advisory Board was constituted, and suggested that the hospital become independent of the parent mission body. Accordingly, the Advisory

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[1] The future of this non-European hospital, in a White residential area, remains somewhat uncertain even today, some sixty years later.

[2] McCord's statement that no other Africans had trained as nurses is not strictly true: see chapter three of this thesis.

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Board became a Board of Management when the American Board of Missions agreed to relinquish its property rights to the valuable hospital site, as well as its financial responsibility for the running of the hospital. A constitution was drawn up, and the Mission Nursing Home became the McCord Zulu Hospital, with its affairs controlled by its Board of Management (which was, and still is, constituted from among prominent local citizens of different races).

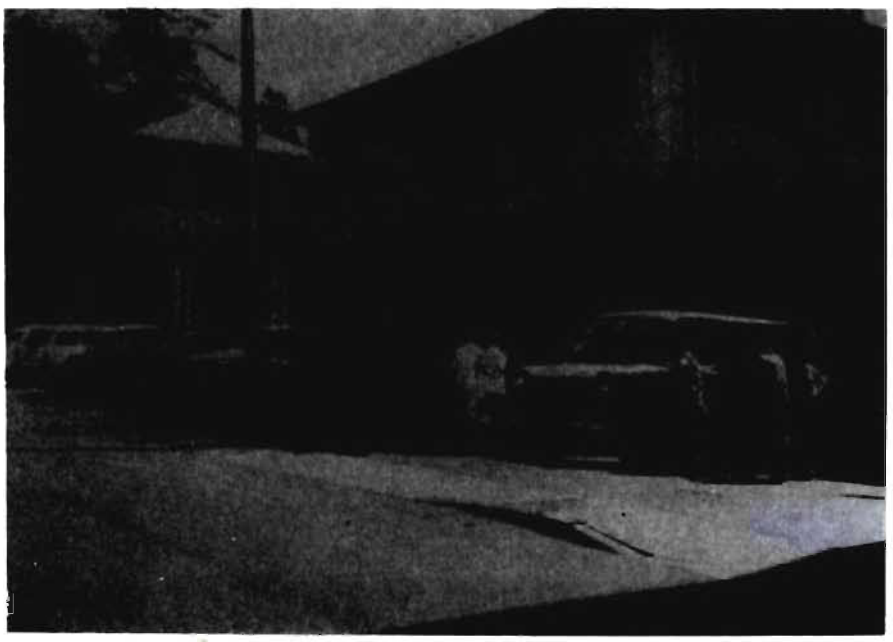
From its very modest beginnings, the McCord Zulu Hospital has grown to be an important modern hospital, of considerable significance within the structure of non-European health services in Durban. In 1970, McCord's had approximately three hundred beds, and employed thirty-five African registered nurses as sisters and staff nurses; plus thirty-six student midwives; and over one hundred and forty general nursing students, in normal circumstances. McCord's has gained fame as an exceptionally good nursing school, and draws some of its students from far beyond the borders of South Africa. No doubt its attraction stems partly from the policy adopted at the beginning:

> "From the time the Mission Nursing Home started to train native nurses, we gave them training equal to that received by White probationers." (McCord and Douglas, 1951:280)

During the period of my research, McCord's was undergoing another crisis period in its history. As a result of the recently raised entrance requirements for general nursing students[1], it appeared that the hospital would have to abandon the training (leading to registration as a trained general nurse) that it had offered since 1924. The hospital authorities considered that they were unlikely to receive sufficient applications to fill the student vacancies, because so few African girls (can afford to) proceed beyond the Junior Certificate in their schooling. It also appeared

[1] Published in the Government Gazette, no. 3792, of 28 November 1969. See chapter three of this thesis for a discussion of these revised requirements.

PLATE I.



(a) McCord Zulu Hospital. Behind the older hospital buildings shown here, is the five-storey main block.

(b) St. Mary's Hospital, Mariannhill.

unlikely, in view of the less-than-ideal working conditions (hours, facilities, equipment and pay), that the hospital could hope to attract suitably qualified nursing tutors to teach the revised syllabi. It was, therefore, decided to discontinue the general training in favour of auxiliary training, for a trial period beginning in 1970. The decision pleased no-one. Within months, it had become clear that the hospital could not be staffed adequately with students undertaking the auxiliary training: the level of knowledge imparted in this course had proved too superficial in relation to the responsibilities students were expected to assume. Thus it was decided to recommence the general training:

> "This step has been taken in faith, for as yet we do not have a full tutorial staff, and we do not know whether a sufficient number of applicants will be forthcoming now that the entrance qualification has been raised."[1]

(b) St. Mary's Hospital, Mariannhill.

St. Mary's is officially slightly smaller than McCord's, having approximately two hundred and forty beds, and employing eighteen lay African registered nurses. Like McCord's, St. Mary's is a training school for both general nurses and midwives, and began training African students shortly after the hospital was opened in 1935. St. Mary's is controlled by the Catholic order of the Sisters of the Precious Blood, most of whom are of German nationality.

Mariannhill Mission is situated some three miles south-west of Pinetown, roughly eighteen miles from the centre of Durban. The mission is largely self-contained, and comprises the convent and monastery, two guest houses, St. Joseph's Cathedral, St. Mary's Hospital (which has a small

[1] Medical Superintendent's Annual Report, 1970:6.

European wing accommodating some thirty patients), a series of educational institutions catering for nursery-school children through to matriculation, and a vocational school specialising in carpentry and book-binding. In addition, the weekly publication umAfrika is printed at the mission; and fresh milk and vegetable requirements are supplied from the mission farm for sale to members of the mission community, most of whom are African nurses, teachers and clerks (apart from members of the religious orders).

St. Mary's trains not only lay nursing students, but nuns as well, and the "religious" students comprise some twenty-five to thirty per cent of the total intake. Senior nursing positions are filled by members of the religious order, so promotion is effectively blocked for the lay trained nurses. The atmosphere of the hospital is restrained, even austere, and the discipline to which the students are subjected is rigorous. Most of the students are themselves Catholic, and in general, they are somewhat older than those at McCord's, since many of them have completed the auxiliary training before commencing general nursing. A majority of the registered nurses is also Catholic.

In general, St. Mary's appears to be much more compact and isolated, and is quieter, than McCord's. Even though it is less than an hour's bus journey from Durban, St. Mary's has the feel of a rural establishment -- quiet, conservative, somewhat strait-laced. However, some attempt is made to meet the social needs of the staff: a swimming pool and tennis court are available at certain times for the use of the nursing staff, and the occasional film is shown. But the main emphasis is on church attendance and religious commitment.

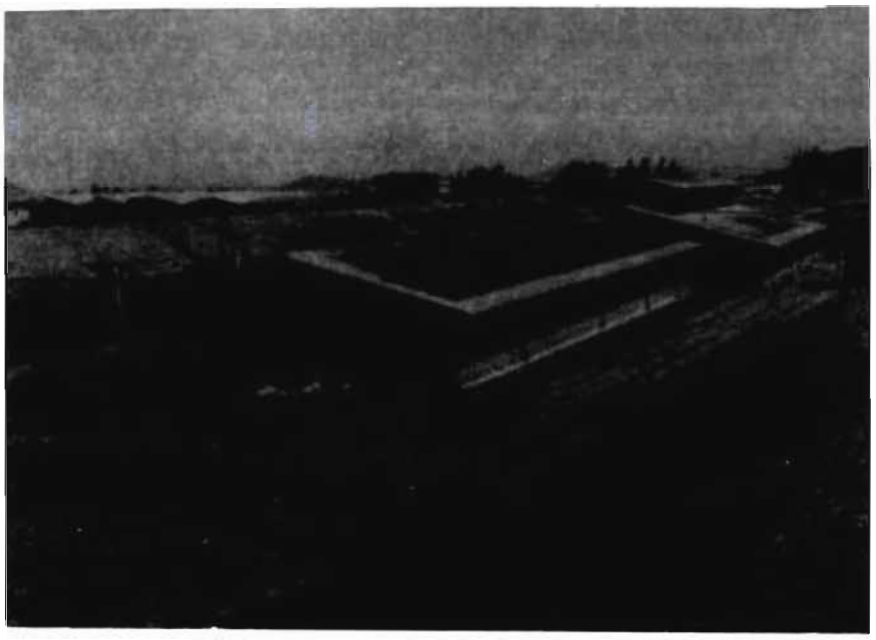
(c) Clairwood Hospital.

Situated in the industrial area of Mobeni, south of Durban, Clairwood Hospital is controlled by the Natal Provincial Administration. Clairwood used to be a military establishment, and the barracks have been converted into wards, each of which accommodates some fifty-odd patients. All told, the hospital has approximately nine hundred and forty beds in use at present, and employs some ninety African registered nurses in posts for staff nurses, sisters and assistant matrons. Although the hospital has its own Outpatients section and does admit serious cases directly to its wards, it is basically a convalescent hospital serving the King Edward VIII Hospital, in Umbilo.

With the exception of an operating theatre, Clairwood has all of the departments that McCord's and St. Mary's have -- medical, surgical, tuberculosis, paediatrics (children) and maternity -- on a very much larger scale, but, unlike the others, Clairwood does not undertake nursing training of any description. Most of the nursing staff are auxiliary nurses and nurse aides, in contrast to McCord's and St. Mary's, where students comprise the majority of the nursing establishment. Of the three Durban hospitals I studied, only Clairwood had posts for African (assistant) matrons and thus, along with other provincial hospitals, held out the best prospects for promotion, for African registered nurses.

Clairwood Hospital has been in existence only thirteen years. Prior to 1958, the site currently housing the hospital, was occupied by the Institute of Family and Community Health, a multi-disciplinary body concerned with social and preventive medicine, which is now defunct.

PLATE II.



(a) Clairwood Hospital, situated in the Durban industrial area of Mobeni.

(b) Charles Johnson Memorial Hospital, Nqutu, Zululand.

(d) Charles Johnson Memorial Hospital, Nqutu.

Formerly controlled by the Church of the Province of South Africa (Anglican), what was a seven-bed cottage hospital in 1945, now has nearly four hundred beds, officially, and usually has up to six hundred patients. During this period, the hospital's development has been guided by the medical husband-and-wife team who run the hospital and who have made it their life-work. The nursing staff establishment (which was under review by the Department of Health at the time of research) included approximately forty African registered nurses, some forty student midwives, and roughly one hundred and forty general nursing students.

Auxiliary nursing training began at the Charles Johnson Memorial Hospital in 1948. This four-year training included midwifery, but it qualified the nurse for recognition only within the borders of Natal, until the Nursing Act (Amended) of 1957 brought the auxiliary training within the province of control of the South African Nursing Council.

Training under the S.A.N.C. syllabus for general nurses was begun in 1961, while the older auxiliary training was phased out by the end of 1964. Midwifery training was continued, however. Approximately one hundred and twenty general nurses have trained at the Charles Johnson Memorial Hospital since 1961. However, the recently revised entrance requirements for the general nursing training, have affected C.J.M.H. in much the same way as these have affected the McCord Zulu Hospital. The plan at C.J.M.H. is to train general and auxiliary nurses concurrently from 1971, taking one group of trainees for the general course each January, and one group for auxiliary training each June. The hope is that, in the future, the auxiliary-trained nurses will proceed to the general diploma course. Rural training hospitals,

such as the Charles Johnson Memorial Hospital, attract few well-qualified applicants for training: on average, less than ten per cent of the students at this hospital have been matriculants. Since a standard ten pass, or else enrolment as an auxiliary nurse, is now required for the general training, the alternation of general and auxiliary training courses is the only way in which such hospitals can hope to continue the higher-level training.

The Charles Johnson Memorial Hospital has recently undergone a change in status. On April 1st, 1970, the Department of Bantu Administration (central government) assumed financial responsibility for all mission-controlled hospitals located in the Bantu Homelands and also for some, like the Charles Johnson Memorial Hospital, that are not strictly on tribal land. (Nqutu is a "white spot".) This change means that the Department of Bantu Administration, working through the Department of Health (also central government), will pay the salaries of all staff on the approved establishment, but will not, as far as is known, interfere with the functions of the boards of management of the individual hospitals[1].

It is interesting to note that, while McCord's senior staff expected that financial responsibility for their hospital would be assumed by the Department of Bantu Administration, in the same way as occurred at the Charles Johnson Memorial Hospital, this never materialised, thus raising further doubts about the future of the McCord Zulu Hospital.

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[1] The assumption of financial responsibility for mission hospitals is part of a wider plan to extend and co-ordinate health services in the rural areas. The decentralisation policy, whereby each defined geographical area will be served by one large hospital, which will control and staff a number of sub-stations (each having three or four beds, for emergency and possibly convalescent treatment) and many clinics and medicine depots, is intended to ensure that no-one in that particular area is more than a few miles from skilled medical attention. This decentralisation policy bears considerable resemblance to Russian health services. Obviously, because of the shortage of qualified (African) doctors in South Africa, the registered nurse is a key figure in this plan.

Comparisons and Contrasts among the Four Hospitals Studied.

Modern nursing traces its descent from the ethic of charity among the early Christians, but the extent to which the Christian ethic is emphasised and enforced, varies at different hospitals. Adherence to Christian, and specifically Catholic doctrine, is enforced most strongly at St. Mary's (of the four hospitals covered during the course of this study). All students at St. Mary's are required to attend religious services at least once daily, and although the trained nurses are not forced to attend church with such regularity, they are expected to set an example to the students. At the Charles Johnson Memorial Hospital, in contrast, everyone (including the student nurse) is free to make an individual decision regarding church and chapel attendance[1]. At McCord's, there is no compulsion on registered nurses to attend chapel services, but students are ordinarily required to attend the (very informal) Sunday evening services, which are held in the Nurses' Home. Neither McCord's nor Clairwood have chapels, but in each case one room in the nurses' home has been set aside for use as a chapel, where interdenominational services, conducted by visiting ministers, are held at regular intervals.

One striking contrast between Clairwood and the other three hospitals is that Clairwood, although by far the largest, does not undertake any kind of nursing training. McCord's, St. Mary's and Charles Johnson Memorial hospitals are all recognised training hospitals for both general nursing and midwifery. Hence the work problems faced by qualified nurses working at Clairwood, are somewhat different to those faced by registered nurses working at training hospitals. African registered nurses regard auxiliary nurses and nurse aides as being difficult to work with, less responsible, more stubborn

[1] This policy is not characteristic of mission hospitals in general.

and slap-dash in their work than are students, because there are no examination or promotion incentives for semi- and unqualified nursing personnel.

At all four of the hospitals studied, the registered nurses on their staffs come from diverse tribal and home backgrounds, and have trained at many different hospitals. Tribal diversity among the registered nurses is most marked at Charles Johnson Memorial and St. Mary's hospitals, and perhaps this diversity is a result of their rural localities: I have already mentioned that the isolation of rural hospitals results in a rapid rate of staff turnover, since the jobs are regarded as temporary.

Any attempt to rank these four hospitals in terms of their prestige in the eyes of African nurses, would have to take into account a number of cross-cutting factors. McCord Zulu Hospital is a renowned training school, but salaries at Clairwood (a provincial institution) are more attractive, even though working relationships are regarded as being more difficult. Particularly for those nurses living in Lamontville, however, Clairwood is extremely convenient in being, at most, twenty minutes' bus journey from home. St. Mary's has the advantages of a rural location -- including staff quarters on mission territory -- and yet it is within easy commuting distance of Durban, for shopping and entertainment purposes: but salaries are lower than those on provincial scales. Charles Johnson Memorial Hospital has what is probably the single greatest disadvantage in its truly rural location, because the majority of African nurses are urban-oriented, and relatively few are willing to stay in the country on anything more than a temporary basis. Again, salaries are lower than those on provincial scales. However, the Charles Johnson Memorial Hospital is well-known and respected by African nurses, (and doctors), on account of its ethic of non-racialism,

which is practised as well as preached. This factor alone, in South Africa, gives it a positive rating despite its other disadvantages. Furthermore, C.J.M.H. makes great efforts to cater for the social needs of its nursing staff, and maintains regular contact through sport (especially tennis) and music and dancing, with other hospitals as far afield as Pietermaritzburg and Empangeni, and with the University of Zululand at Ngoye. There is far more social activity at the "Charlie J" than at any of the other hospitals, and life is rarely dull, despite the hospital's rural isolation.

Research Methods.

It was apparent, even before research was begun, that I would have to deviate from such "traditional" techniques of anthropological enquiry as participant observation, since I was undertaking urban research within the framework of South African society. Not only could I not live among my informants, but it was not even possible to visit respondents living in African townships, after normal office hours, because the terms of my permits did not allow this. Hence opportunities for direct observation occurred in the hospitals, among families living on mission terrriory, and, to a limited extent, among informants living in the townships, who were sometimes at home during the periods in which I could visit them.

Open or unstructured interviewing and general conversation thus proved to be the essential techniques on whioh my research depended. Informal discussions, as well as the collection of life history and genealogical material, were dependent on regular interviews with a core number of some twelve individuals, and intermittent interviews with most other nurses working at the three Durban hospitals. Since all of my informants were perfectly fluent in English (their entire nursing training is done in this language or, less frequently, Afrikaans), there were no problems regarding

communication, and I did not need the services of an interpreter at any stage. Indeed, I feel that the presence of a third person at many of these interviews would have proved a hindrance rather than a help, since African nurses are reticent about discussing their private affairs with their colleagues or anyone else. Particularly an outsider from their own racial group, would have upset the balance of confidence to the detriment of my research. However, it would probably have proved useful to employ an assistant to undertake research into home life that I could not do myself: unfortunately my rather slender financial resources did not permit this.

Statistical Information.

The collection of statistical data posed certain additional problems. Although I was given access to staff records at McCord's (for students and trained staff) and St. Mary's (for students), the Natal Provincial Administration authorities refused to allow me to consult any provincial hospital records, despite (additional) requests by the medical superintendents of Clairwood and King Edward VIII hospitals, that I should be allowed to consult non-confidential records.

In order to overcome this serious disability, a short questionnaire[1] was compiled and distributed to African registered nurses working at the following health institutions: King Edward VIII, Clairwood, Wentworth, Point Non-European, King George V, Umlazi Mission, McCord's and St. Mary's hospitals; the Umlazi and Kwa Mashu Polyclinics and the Durban City Health clinics; the Botha's Hill Tuberculosis Settlement; and to industrial nurses working for the Public Utility Transport Corporation. Four other health institutions were omitted as a result of non-co-operation on the part of the controlling authorities; and no attempt was made to contact the very

[1] Mentioned previously: see Appendix I.

small number of registered nurses working in doctors' private surgeries. Copies of this questionnaire, with its accompanying letter of explanation and stamped, addressed envelope, were distributed to nine hundred and thirty (930) African registered nurses, two hundred and twenty-six (226) of whom returned completed forms -- a return rate of 24,3%.

The use of a postal questionnaire has not, to the best of my knowledge, been a common method of anthropological enquiry in the past. In this particular instance, however, it was the only way in which I could possibly acquire the information needed and, to the extent that this was achieved, I consider that the use of the questionnaire was justified. It was fortunate that nurses are both literate and quite familiar with the European habit of collecting information by means of standardised forms; and that the network of members of the local African branch of the South African Nursing Association, the Ogwini Branch, was available to remind colleagues to complete and return the questionnaire forms.

Research Difficulties.

My major difficulties have been discussed already: the refusal of the Natal Provincial Administration authorities to allow me access to hospital records; and the restrictions placed upon my movements in the African townships by the terms of my permits. Difficulties of a less serious nature arose fairly frequently with the last-minute alteration of off-duty times of informants, which usually resulted in cancelled or abandoned appointments. While it was usually possible to substitute respondents by interviewing whoever happened to be available, the cancellation of an appointment with an important informant usually entailed waiting at least one week before another suitable time could be found, hence a fair amount of time was,

perforce, wasted, in a sense.

A Note Regarding Identity.

Finally, a point of identity requires mention. In addition to my anthropological training, I am myself a qualified nurse, having completed the Bachelor of Social Science (Nursing) degree of the University of Natal, in 1968. During my training, I had become aware of the hostility that is often harboured by non-European nurses towards their European counterparts: hostility that is a result both of differential salaries and of the legal provision that a non-European nurse may not exercise authority over a European, even if she holds equal or higher qualifications. I therefore deemed it wiser not to reveal a qualification which I have never used nor intend to, and this assessment was reinforced during the course of my research. The automatic assumption that I was not involved in the world of nursing -- which, then and now, was and is correct -- was, I think, one of the reasons for the African nurses' wholehearted acceptance of my enquiries, and willing co-operation. The possibility that I might be a nurse was, fortunately, never raised.

At the same time, however, my personal knowledge of the nursing world was essential in assessing what went on in the hospital wards, the quality of the nursing service, normal and abnormal hierarchical relationships, and so on. Furthermore, my knowledge of hospital life equipped me with a basis for comparing African hospitals with my own experiences at Addington Hospital, in Durban, where the practical aspect of the nursing degree required that I work for four years. I hope that this experience did not impair too seriously my objectivity in observation, for my awareness of such a possibility should have minimised it.

In conolusion, I should perhaps remark that, contrary to the reported experiences of some anthropologists[1], my respondents did not regard my investigations with amazement, incredulity, suspicion or any of the other apparently standard reactions. They were interested, not only in the reasons for the study itself, but in the whole field of anthropology. In fact, I was invited to deliver a short address to members of the Ogwini Branch on the subject of anthropology. Some of these nurses had personal knowledge of anthropologists (some were related to, or knew, Zulu anthropologists who have trained at the University of Natal). Some had read anthropological writings. Some would have made good anthropologists themselves!

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[1] See, for example, Geddes, W. R. 1957. Nine Dayak Nights. Oxford University Press Paperbacks, New York. p. xii; and Beattie, J. 1965. Understanding An African Kingdom: Bunyoro. Holt-Rinehart, New York. p. 14.

CHAPTER TWO

THE CONCEPT OF ELITES IN MODERN AFRICA

The bulk of this thesis is concerned with an analysis of my research data in terms of the elite concept. Before attempting to show, in detail, why African nurses should be regarded as part of the modern elite stratum, however, I wish to consider, again in some detail, the theoretical implications underlying the concept of elites, as this concept has been developed by Nadel (1956) and refined by Lloyd and others.

Differing Uses of the Term "Elite".

In one common usage, the term elite refers to the elect, the aristocracy. This usage has connotations of excellence in achievement, yet, paradoxically, smacks of an hereditary establishment. Elite is seldom used in daily conversation, however, perhaps as a result of the declining importance, in our own society, of hereditary systems of government and social class. The term elite is now mostly used among specialists, particularly political scientists and sociologists.

Pareto (1935) was one of the first to adapt "elite" for sociological usage. He used it to refer, firstly, to those persons in any particular group who could be rated, in terms of achievement, above their fellows; and secondly, to the governing class. Elaborating on Pareto's work, Mosca (1939) developed more fully the concept of a ruling elite. Despite these early attempts to refine the use of the term, however, looseness in terminology has persisted among sociologists. Provided one indicates, in broad terms, how one intends using the term "elite", it seems to have become common

practice to use it almost as one likes.

More recently, then, one finds that the elite concept has been taken over by social anthropologists working in the politically emergent states of Africa, and they have used "elite" to refer to those indigenous persons who have broken away from the traditional structure of their society -- the literate, and the highly educated.

It is, therefore, not surprising, in view of the many differing and diffuse uses of "elite", that the whole concept of elites has become confusing and ambiguous. It is possible, though, in the past, that part of the value of the term has lain precisely in its vagueness, as Nadel (1956:414) believes. The following sections of this chapter will attempt to discuss and, perhaps, make more definite, some of the more important features of elites in modern Africa.

Definitional Features of Elites in Modern Africa.

The first, very obvious point to be made, is that the elite category must incorporate a plurality of persons, and this "stratum of the population" (Nadel, 1956:413) is more or less organised into an identifiable group or quasi-group. A single individual may have elite status, but he or she cannot, alone, constitute an elite. Although the elite stratum comprises a number of individuals, however, the total number is usually a very small proportion of the total population, and elites thus constitute a minority group within the society as a whole.

Secondly, elites must be aware of their own identity as elites, and of their position as a high-status group. As Nadel (1956:415) puts it:

> "...elites, as here understood, must have some degree of corporateness, group character and exclusiveness...they must form a more or less self-conscious unit within the society, with its particular entitlements, duties and rules of conduct in general."

As a third consideration, admission to the elite stratum must be restricted: "...there must be barriers to admission..." (Nadel, 1956:415). The ways in which admission is restricted, however, would appear to vary. In modern Africa, the restriction has resulted primarily from limited opportunities in the field of education. Thus while the requirements for entrance to the modern African elite are, theoretically, open to anyone, restricted opportunities have effectively closed the elite stratum almost as tightly as does any explicit restriction on the admission of new personnel by members of the existing elite, jealously guarding their privileged position. Explicit restrictions on entry are, of course, found in the professions, but it is usually open to anyone to try to attain professional qualifications. It is the generally low levels of education and the restricted opportunities for acquiring it which have, in the past, caused the elite stratum in Africa to be partially closed. The modern African elite is not closed in a manner comparable to some of the European aristocracies prior to the French and Industrial Revolutions, however. Rather, the African elite is a partially closed collectivity in an opening society, and is itself part of the modernising process.

In noting the partial closure of the elite stratum, I have implied a fourth criterion of elite status: that is, that the attainment of such status is dependent upon the possession of certain acquired skills and attributes. The modern elite is not based on ascribed status, and will, therefore, be found only in a society that is open or opening. By definition, then, the use of the term elite to refer to persons filling ascribed

positions in traditional society, is inappropriate (or at least different) unless there is some minimum measure of openness manifested in competition for position, such competition being based upon acquired skills. To write of the "tribal elite" or "traditional elite" when referring to persons holding positions of authority in the traditional political systems of modern African states, as Busia (1956), Ngcobo (1956) and others have done, is to use the term elite in a different sense from that which it has acquired in its modern anthropological context. Such usage confuses the governing elite of Pareto and Mosca with the modern usage, which refers to an anti-traditional minority group, members of which have influence because of their successful, though not necessarily total, adaptation to a different and dominant culture.

Because elite status is dependent upon achievement, and because admission to the elite stratum is restricted largely on the basis of occupational qualifications, the elite category as a whole is composed of a number of sub-groups, or perhaps status-groups, which are based on occupational distinctions. Some occupations, such as clerical jobs, carry a general educational requirement; most professions admit only specifically-trained personnel. In modern Africa, the allocation of such occupational categories to the ranks of the elites, has often caused confusion, for what may be regarded as an elite occupation in one country may not be regarded as such elsewhere, as a result of differing overall levels of education. But however much these may differ from one country to the next, there nevertheless exist certain minimum qualifications for elite recognition in all countries.

In passing, it should be noted that the practice of defining, on the basis of occupation, who may or may not be among the elites in developing countries, has another serious drawback, since changes may occur in the ranks of the elite with the advent of new economic and political factors. In

developing a country's economy, for instance, new jobs may be created and assume immediate importance in the occupational structure: highly skilled technical occupations have recently assumed importance in Africa, for example, where previously these had not existed. When such economic changes occur, occupations which were previously highly rated, may lose much of their importance, particularly in a relative sense. Thus changes in the economic structure of a society may open up new elite occupations, while causing others, previously important, to become somewhat redundant, and lose prestige. Political changes may cause similar shifts: the relinquishing of political power by colonial governments, for instance, has brought into prominence a new political elite in Africa, based on power rather than advanced education and/or wealth. And, in very recent times, the military establishment in African states has emerged as a powerful factor in politics as well. As Southall (1966:348) notes:

> "...an elite taken as a whole is a dynamic category rather than a group".

To return to the identifying characteristics of elites in modern Africa particularly, the final and perhaps crucial factor is their high social status and prestige, or what Nadel (1956:417 ff.) terms their "generalised superiority", which gives rise to their imitability. This social superiority is quite distinct from the power, or authority wielded by a governing elite, though the two are frequently found in association. The high social status of elites is partly a result of their achievement in meeting the entrance requirements for admission to the elite stratum (what Nadel (1956:418) terms "preconditions" for elite status); but it is also related to the elites' influence as a result of their position as a general reference group in the wider society (what Nadel (1956:418) calls the consequences or concomitants of this status). The preconditions for elite

status are not normally imitable, but some of the concomitants of this status are. Thus the elites' manners and morals, life styles and interests stand as models to be copied by the society at large.

The imitability of the elites may extend beyond the material plane. Their power of innovation may, in fact, include change within the value system itself of the culture in question. Insofar as elites in Africa are actively promoting a new, western-based standard at the expense of the traditional culture, they are indeed attempting to alter the structure of values within their societies. In fact, the elites may well regard themselves as having an educative function in promoting the new cultural standard among non-elites.

However, where at least two basic cultural standards are in operation, as occurs in the changing societies of Africa, the cultural pattern represented in the lives of the elites may <u>not</u> be considered imitable, or even desirable, by the section of the population which is still positively committed to the traditional culture. For these people, the elites represent <u>not</u> a reference group for standards, values and behaviour, but rather a culturally deviant sub-group. In such a situation, what acceptability the elites have among this section of the population, will derive from their political and economic power rather than their "generalised superiority" in the social sphere.

Of course, as Nadel (1956:418) does indicate, not all of the qualities of elites can be equally imitable, especially those characteristics which actually confer elite status. It happens, then, that certain material possessions, such as clothes, furniture and motor cars, become symbolic of the achievement of elite status, and conspicuous consumption becomes apparent

among those who strive towards identification with the elites. The model of the elite life style that is presented to the population at large, is often unrealistic, and usually unattainable by those seeking elite status, but, far from invalidating the model, this situation merely emphasises the superiority of the elites. The gap between elites and non-elites in terms of their respective standards of living, is all the more noticeable in that it has arisen in societies where, in the traditional past, some measure of egalitarianism prevailed. As Lloyd (1966:12-13) indicates, in the situation where elites have incomes at least ten times those of the working masses, the "sub-elites" (those on the fringes of elite status) may be the more significant reference group in practical terms, for the masses. The lower incomes of these sub-elites result in a life-style that is "scaled down" from that of the elite proper, and is thus more open to imitation.

Having discussed the important general identifying characteristics of modern African elites, I now wish to discuss why, in Africa particularly, the elite concept has been and still is used in preference to analysis in terms of social class.

The Elite Concept in Relation to Social Class.

In Africa, where radical social and cultural change has already occurred and is still progressing, at least two distinct cultural standards may be identified. There are the "traditional" sets of norms and values, and there are those which have resulted from contact with the different cultures of western Europe. In earlier times, these two cultural standards were polarised: European colonists and expatriates exhibited the western pattern, while the vast majority of Africans continued their traditional ways with little modification. Between these two groups, however, there arose a small but

significant intercalary group, the so-called "African middle class", members of which, although they could not be regarded as wholly western in culture, were nevertheless far removed from the traditional background of their fellow Africans. These évolués were the products of the early mission schools in Africa, and were educated in the British or French traditions. They formed a focal point in communication between European and African, and were seen as occupying a social position somewhere between that of the governing European elite, and that of the bulk of the African population: hence the term "middle class". While their position was, in many respects, sociologically marginal in that they were never identified as belonging wholly to either major section, these évolués became trained and skilled participants in the new money economy, thus deriving greater material benefits than their uneducated fellow Africans. In turn, their children benefited in similar manner. Today, the elite descendants of these early évolués usually fill highly skilled technical and professional positions, and have moved still closer to the western cultural pattern.

The modernisation process is reflected not only in the occupations of the elites, however, but in their life style, interests and leisure pursuits as well. Expensively furnished houses; well-cut clothing; privately-owned motor cars; boarding school education for the children; membership of orthodox, status-giving churches -- all are indices of elitism in modern Africa. The interests and activities of the elites are made possible by their relatively high incomes (which in turn are related to their occupations), and their expenditure patterns reflect the wide discrepancy between their own values and those of the non-elite, traditionally-oriented masses. Thus the elites are distinguished from non-elites both in structural and in cultural[1]

[1] Mayer (1963:6) has discussed the distinction between structure and culture in some detail, with reference to the process of urbanisation. My own interest lies in the relevance the structure/culture distinction has for the wider process of modernisation, without a specifically urban referent.

terms. As will be shown later, for African nurses in particular, social relationships and roles, as well as occupation, are some of the means whereby elites differentiate themselves from non-elites; but equally well, some very important distinctions between elites and non-elites depend not on these structural aspects, but on the cultural aspects of values, attitudes and behaviour. While structural differentiation is important, the distinctions based on culture are perhaps more striking when one looks at African elites against the background of African non-elites.

The high status and prestige which characterise elites in Africa, result from their ability to manipulate and work within the new and dominant cultural pattern based on the western model, which ability in turn is closely related to occupation. The occupational structure, of course, rests on economic development, which is regarded, particularly by the elites, as vitally necessary in African states. Yet few Africans have been prepared to cope with the new world of urban, industrial technology, and occupational specialisation, which economic development entails. The elites, however, not only work within the modern framework: insofar as they fill key administrative, technical and professional posts in the modern structure, they in fact control it, and it is on this basis that their prestige and high status rest. The elites are actually outside the traditional framework, even though they retain links with it, for example, through kinship ties.

While traditional and modern structures continue to be found in association with differing cultural frameworks; and while two (tradition-based and modern) cultural patterns continue to exist simultaneously within a single overall social structure (that is, the modern state) -- is it really permissible to consider analysing the position of any section of the total society in terms of the class concept? One may talk, of course, as

sociologists dealing with Western societies have done, of the sub-cultures of different classes. Such sub-cultures are, however, merely variants on a common cultural theme. But when one encounters two (or more) distinct groups or populations, each having a distinct and separate culture, can one legitimately regard these groups as two (or more) different social classes within a single social system? I think not. Some current terminological problems have arisen from precisely this source of confusion in the past. The "African middle class", for instance, earned this mistaken appellation because certain individual Africans were seen to be somewhat different, culturally, from the majority of the indigenous population, and could thus be regarded as a kind of buffer group between European and African. It seems unlikely that the normal criteria of class identification,

> "...including income, occupation, accent, spending habits, residence, culture, leisure pursuits, clothes, education, moral attitudes and relationships with other individuals... (plus) a look at (the individual's) family, including the generation of his parents, himself and his children..."[1]

were applied systematically when individual Africans were assigned to the "African middle class". The term "middle class" was really a convenient shorthand reference to Africans who did not fit into the European stereotype of "African"; and today's social scientists are still trying to unravel the confusion that has resulted from this misuse of the class concept. The issue of cultural difference, in modern systems of social stratification in Africa, remains crucial.

Although there is evidence to suggest that the educated stratum of one generation contributes a significant proportion of potential elites to the next generation (because educated parents educate their children), it would

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[1] Quoted from Lewis, R. N. and Maude, A. 1949. The English Middle Classes Pelican Books, Harmondsworth. Since the original was not available, I have re-quoted from Mitchell, J. C. (1956).

appear that a majority of today's elites come from traditional home backgrounds[1]. There is no evidence to suggest that a semi-closed and self-perpetuating "educated class" exists in African countries today. As Plotnicov (1970:269) indicates:

> "In the view of many scholars it would be premature now to speak of the existence of social classes in Africa".

However, if any group in Africa does begin to approximate a social class, it is the elite stratum, for elites have been reported to manifest something resembling class consciousness in their behaviour and value systems. Plotnicov (1970:271) opts for the view that African elites do form a single social class, despite the admitted lack of other classes; that elites are the focus around which a class system is beginning to crystallise; and that an incipient middle class, of lesser status than the elites, but striving for identification with them, is identifiable; and that the bulk of the population "...as a residual category, will continue to form the base of the pyramid" (Plotnicov, 1970:300). Plotnicov would, I think, agree with Ardener (1967:64) in his view that "...the elite concept in the social anthropology of Africa is near the end of its period of scientific usefulness".

However, Plotnicov (1970:274 and 292) also points to the cultural gulf between elites (and those striving toward elite status) and the bulk of the population. He states that:

> "People in Jos have no difficulty determining whether an individual is a traditionalist or a modernist for the cultural indications are many and clear..."
>
> "...in Jos, part of the population seeks to identify with the modern African elite and strives to be accepted into

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[1] Clignet and Foster (1964:357), for instance, dealing with samples of secondary-school students in Ghana and the Ivory Coast, note that "...these systems...recruit from very broad segments of the population...almost 70% of Ivory Coast students and nearly 40% of Ghanaian students come from farming families in which parents are overwhelmingly illiterate".

> its ranks. This is, of course, untrue for most of the population, who sorely lack even a modest amount of modern elite qualifying attributes, and who adhere to traditional systems of prestige."

Thus, while I am in complete agreement with Plotnicov (1970:300) when he states that African countries can be expected to develop class systems as their economies undergo modernisation, I do think that class analysis remains inappropriate at present. Not until further socio-cultural change has effected much greater cultural homogeneity in the total populations, to replace the existing heterogeneity between modern and traditional outlooks, will the concept of social class be able to add more to our understanding of modern African social systems, than the elite concept[1]. This is so because the high status and prestige of African elites result from their ability to work within a modern cultural framework based on that of the West.

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[1] Brandel-Syrier (1971:xxvii and xxix) has also objected to the use of the class concept, in her discussion regarding the position of African elites. Her argument would appear to be that the total South African society cannot be analysed in terms of one class system, since the similar segment of African society does not "...enmesh associatively with the European middle class in South Africa". This implies, at least to my way of thinking, that the class concept could nevertheless be used within distinct racial sub-sections of the South African social structure. That is, one could identify upper, middle and lower classes for European, Indian, African and Coloured populations, and have four class systems instead of one. (Is this not precisely what the policy of separate development is intended to achieve?) Yet Brandel-Syrier also denies the applicability of the class concept to Africans in particular, though I find her reason for doing so rather obscure. She states (1971:xxix) that:

> "...to consider them in terms of 'European' class patterns... raises expectations about these Bantu individuals which they cannot possibly fulfil".

That is, she seems to attach some evaluative notion to the term "class", and rejects its use for that reason. Later on, however, she is willing to apply the term "upper class" to describe the position of African elites within their own racial (and local) community. These ambiguities are, perhaps, a further demonstration of the complexities surrounding the use of the term "class" -- especially in the South African context.

My own reason for rejecting the class concept in its totality for the present, pertains to the cultural distinctiveness of the elites, compared to the majority of the African population. It is my impression that elites are culturally distinct in both rural and urban areas, thus impeding the use of class analysis even in the urban context at present. Obviously, this situation can and must be expected to alter as economic development proceeds.

I have mentioned previously that education is the primary key to effective participation in a western-based economy. Occupational participation in turn yields financial rewards, which make possible the acquisition of certain material possessions, which symbolise the high status of those who own them. Thus conspicuous consumption becomes evident. Yet studies of occupational prestige undertaken in West, Central and South Africa, would appear to indicate that education is more important than wealth in the context of social status among Africans. The trader, for instance, may have an income well in excess of professionals such as teachers and ministers of religion, but he is consistently ranked lower on prestige scales. Indeed, in West Africa particularly, trading as an occupation is located within the traditional structure rather than the modern, and the traders' homes and attitudes are likewise traditionally-oriented (Lloyd, 1967 b). The ability of such wealthy traders to utilise the new cultural standard, is limited to copying patterns of consumption of the elites proper. While the acquisition of such material indices of financial success as electric stoves and refrigerators, may mark the trader as "progressive" within the traditional society, his social status remains lower than that of the relatively lowly clerk, who earns much less, but whose occupation is clearly located outside the traditional framework. Thus, although educated Africans may be considerably less wealthy than many traders, their education and "western" occupations entitle them to the elite status denied to most traders.

This cultural referent of elite status, and the (structural) occupational foundations on which it rests, allow us to circumvent some of the thorny problems associated with "urbanisation" and socio-cultural change. While the towns and cities are obviously where most elites will be found -- for occupational openings suited to their qualifications are clustered in urban areas -- there is no valid reason why modern elites should not arise

or exist in rural areas where western cultural institutions are in operation, such as schools and hospitals. Hence individuals may be found who have been born, raised and educated in rural areas, but who have, through education and professional training, become participants in a completely different culture from the one into which they were born -- a culture, moreover, which is normally associated very firmly with town life and urbanisation. And when such individuals move into town for the first time (if they ever do), they are readily accepted into the elite stratum by their urban counterparts. Thus Wilson and Mafeje (1963:30 and 139) remark:

> "...teachers and other educated men and women from the oountry are very readily absorbed into the ooscuse-me group, though they have lived only a short time in town..."
>
> "...'school people' are more readily absorbed in town than the uneducated, and professional men and women -- teaohers, nurses, lawyers, doctors -- are accepted immediately into the ooscuse-me group".

Some Differences Between Independent African States and South Africa Insofar As These Affect the Structure of the Elite Stratum.

Probably the single most important distinction between independent African countries and the Republic of South Africa lies in the obvious differences in their respective political systems. In South Africa, the powers of government are vested in the hands of the minority White section of the total population, whereas in most other African states, political authority is now in the hands of Africans, including the elites. Members of the elite stratum in these countries occupy the highest administrative and political offices, whereas in South Africa, this process of Africanisation has not yet occurred, except to a very limited extent in the "Homelands". Thus in South Africa, the African elite does not include a governing, or power elite, and in this respect, the situation resembles that of the colonial era in what is

now independent Africa. We are seeing now, however, the emergence of what might be described as a circumscribed political elite in South Africa -- circumscribed in that the political authority held by leaders such as Paramount Chief Matanzima (Transkei) and Chief Buthelezi (Zululand), is restricted to a clearly defined section of the total population in an equally clearly defined segment of the territory. What influence the emergence of such educated and, therefore, elite, political leaders will have on the elite structure in South Africa, remains to be seen, for their positions and influence, or power, are confined within a neo-traditional system of chieftainship, rather than being based on the western model of democratic government, as is theoretically the case in the rest of Africa.

A second important difference between South Africa and West Africa particularly, concerns the respective educational qualifications and occupations of their elites. In the literature on West Africa, the assignment of groups of individuals to elite status has been done in accordance with the primary criterion of education, for this has determined both occupation and social position in the non-traditional urban communities. The system of western education, initially introduced into Africa by missionaries, has been responsible for the social changes which have produced the new elites. In the colonial past, because education led to a well-paid job, the elite stratum was synonymous with the educated sector of the population. Thus it was possible for writers such as Busia (1956:430) and Tardits (1956:495) to equate elite status with literacy (in the sense of a minimum of six years of schooling), provided that the literacy rate in the total population was ten per cent or less. This crude index of elite status was formulated in the early nineteen fifties, and is probably no longer applicable in West African countries. Certainly it is inapplicable in South Africa today, where the literacy rate is supposedly high.

Despite one of the highest literacy rates in Africa, however, there are few professionally qualified African men in South Africa. In a total African population of nearly 15 000 000[1], there are probably not more than 3 500[2] university graduates, male and female; of whom less than ten per cent are in the fields of law, medicine and university lecturing. From Appendix II, it may be seen that there were greater numbers of African women professionals (including nurses) than men, in 1960, and it seems probable that this gap has widened in the past decade, although the 1970 Census figures are, unfortunately, not yet available. Thus in South Africa there exists a female-dominated elite stratum, which has had certain social consequences (which will be examined later in this thesis) that appear to be a reversal of the situation common in West Africa, particularly in the nineteen fifties.

South Africa has, then, a relatively insignificant male elite, and indeed, South African circumstances appear to have favoured the rise of a female elite. In the past two decades, for instance, nursing is one field to which African women have been actively recruited. Such was the impetus given to the training of African nurses, that today there are some ten thousand fully qualified, registered nurses, and over six thousand auxiliary nurses[3] in the African population. Thus African nurses alone constitute an extremely significant proportion of the total elite stratum, and the registered nurses alone may outnumber those men who are recognised by the African community as elites, by as much as two to one. One result of this situation, which I shall describe in detail later, is that in South Africa one finds professionally qualified women complaining about the dearth of men who may be regarded as their status equals and, therefore, suitable marriage partners -- the

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[1] Preliminary 1970 Census figures.

[2] Calculated from figures derived from the annual Survey of Race Relations, compiled by M. Horrell: 1960 - 1970.

[3] Figures supplied by the South African Nursing Council: correct as at 31 December 1969.

reverse of the situation reported from West Africa in the nineteen-fifties[1]. The imbalance in favour of women, in the South African elite stratum, would appear to be unique in Africa.

A third major structural difference affecting the position of the elites, is that this distinct female elite, in South Africa, has been created from a less educated stratum of the population than would be the case in West Africa. Taking the nursing profession in particular, only 18,1% (41 of a total of 226) of African registered nurses working in the Durban area, who responded to my research questionnaire, had achieved matriculation standard in their schooling. Thus in South Africa, we see not only a dominant female elite, but the paradoxical situation of a female elite whose schooling is, in the majority of cases, lower than that of many non-professional, non-elite men. Of course, in this particular case, the deficiency in school education is more than compensated by the professional training received by these women.

These differences between the structures of the elite strata in South Africa and other African states are, at least in part, attributable to policy differences regarding education and occupation. Official policy and legal statutes can have, and have had, important effects on the structure of the elite stratum. Some effects of official policies may be seen, particularly in South Africa, in the history of the nursing profession among Africans, which history also shows some of the factors that have helped to confer elite status on the members of that profession.

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[1] Jahoda (1955:79, footnote 13) quotes Mr. Kwesi Lamptey as stating in the Gold Coast Legislative Assembly:

> "One of the causes of unhappy marriages is that the educational standards of the men and the women do not agree...It is the duty of the government to see that the education of women is accelerated so that social upheavals, or married life which is being wrecked as a result of this, may be corrected."

CHAPTER THREE

THE HISTORY OF THE NURSING PROFESSION IN SOUTH AFRICA, WITH SPECIAL REFERENCE TO AFRICANS

The formal training of Africans to undertake nursing duties, has been in progress in South Africa for over one hundred years. During the crisis following the Xhosa Cattle Killing in 1856, four domestic servants were seconded to the Native Hospital, Kingwilliamstown, and became the first Africans in South Africa to be gainfully employed as nurses, or nursing assistants (Searle, 1965:129); and one of these women was retained in a permanent position at the hospital when the crisis period was over. In 1863, a formal training scheme for African nurses was inaugurated at Grey Hospital, Kingwilliamstown. Despite this early start, however, very few African girls entered nursing for the next sixty years, largely because there were so few who had been educated to a level that hospital authorities considered high enough to enable them to adjust to the concepts of western medicine and nursing.

At this period in the mid-nineteenth century, when the idea of training African girls to perform nursing duties, was beginning to take root in South Africa, Florence Nightingale was battling, in Britain, to establish nursing as a vocation suitable for young women from respectable social backgrounds, and to place the training of nurses on a sound and recognised basis. By 1877, the concept of hospital certification, for nurses who had successfully completed a course of training, had been introduced in South Africa at the Carnarvon Hospital, Kimberley, for European nurses. The first hospital to introduce training leading to the award of a hospital certificate for African nurses, in 1902, was Lovedale Hospital, a mission institution in Victoria East (Searle,

1965:268).

By this time, however, the Cape Colony had become the first country in the world to introduce legal provision for the voluntary registration of suitably qualified nurses, on a register maintained by the Colonial Medical Council. Such registration provided a measure of standardisation and recognition for the diverse trainings received at different hospitals, since a nurse could become registered only if she passed the examination conducted by the Colonial Medical Council. In 1892, twenty-two European nurses were admitted to this register, but it was not until January 1908, sixteen years later, that the first African, Cecilia Makiwane, was admitted.

Ceoilia Makiwane was already a qualified teacher when she entered Lovedale Hospital in 1903, to begin nursing training. She appears to have started a trend (that of teachers re-training as nurses), which still continues today. After she had been awarded the hospital certificate in 1907, Cecilia Makiwane was sent to the nearby Butterworth Hospital (a European institution) for several months' further training, prior to sitting the Colonial Medical Council examination, in December 1907. She was admitted to the register on 8 January 1908. Cecilia Makiwane's achievement in becoming the first fully qualified and registered African nurse in what is today the Republic of South Africa, is currently being honoured in the construction of a statue of her, which will be erected, when complete, in the grounds of Lovedale Hospital (which is today under the control of the Cape Provincial Administration). But beyond her personal achievement, the significance of her registration was that:

> "The Colonial Medical Council had thus accepted the principle that the register was open to all races provided they could reach the desired standard in the examination after undergoing an approved course of training." (Searle, 1965:269)

The Role of the Missions.

African education was, until some thirty years ago, sponsored, financed and controlled almost exclusively by mission institutions. Even today, the majority of nursing students at the McCord Zulu Hospital, and at St. Mary's and Charles Johnson Memorial hospitals, are the products of mission-controlled secondary schools. Western education, of course, was regarded by the missionaries in Africa, as being extremely important in the process of converting pagans to Christianity.

The missions led the way not only in the field of education, however, for curing the African sick was also largely ignored by ordinary European doctors, since it brought few rewards. Consequently, those who practised medicine among Africans in the nineteenth century, were, almost exclusively, missionary doctors. However eccentric some missionaries may appear in retrospect, it must be remembered that most of them subscribed to the idea of educating Africans to serve their own people, and indeed put this policy into practice.

Not surprisingly, their insistence on training Africans brought difficulties for the missionaries. For example, in order to provide personnel to meet the needs of the public in the field of health, some missionaries advocated the introduction of lower-level training in medicine and nursing, for Africans, than that demanded for Europeans undertaking the same tasks. Interestingly, such proposals were rejected (by nurses, doctors and the Colonial Medical Council), largely because of the fear of fee-cutting. The European nurse, for instance, was not prepared to countenance the idea of an African, with less training, depriving her of private patients because the African could afford to charge less for her services. The same objection held

for the medical profession, which, at this time, controlled the nursing profession as well. What the medical profession would not tolerate for itself, it could not sanction in nursing, for fear of setting a precedent[1]. As a result of this situation, training courses, examinations and standards were maintained at identical levels for Europeans and Africans, despite the pressure of work this caused for those ministering to the African population. However, the maintenance of identical professional standards for Africans and Europeans, in nursing particularly, has been an important factor in the prestige attaching to this profession among Africans. But the maintenance of such high standards also resulted in a very gradual expansion in the numbers of Africans who became nurses: some fifteen years elapsed between the time that Cecilia Makiwane was registered as a qualified nurse and the time that the second African nurse passed the qualifying examination, in the nineteen-twenties.

For some fifteen years, then, Cecilia Makiwane was the sole representative -- in the vanguard, perhaps -- of the trained nurse elite. However, in terms of the first criterion of elite status (that is, there must be a plurality of individuals), discussed in chapter two, an elite cannot consist of a single individual! Thus it would be more accurate to regard Cecilia Makiwane as an innovating deviant in her time, rather than the original representative of today's nurse-elites. From the nineteen-twenties, however, one can trace the development of this elite plurality, as more individuals were drawn into the small but expanding group of trained, registered African nurses.

By the nineteen-thirties, government hospitals had begun to follow the lead of the mission institutions in training programmes for African nurses. Apparently, however, they were less successful with their students than were

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[1] Today, proposals to introduce training for medical aides, are opposed vehemently by African doctors and medical students, who regard such proposals as threats to their own position.

the mission hospitals.

> "Yet our girls were of the same blood as those who failed in other institutions, particularly in the government hospitals. Why did they make such excellent nurses, whereas Zulu girls proved undependable in other hospitals? I believe that the difference at McCord's came from balancing discipline with play, from treating the girls as responsible individuals deserving of trust, and from impressing upon them the ideals of their calling...
> Some other hospitals treated probationers as inferiors or incompetents who must constantly be watched, and who would even then prove unreliable. If they sensed from their superiors' attitude that only the worst was expected, what incentive was there to give of their best?" (McCord and Douglas, 1951:279)

The missionary policy of deliberate inculcation of international ethics, both of nursing and of Christianity, into African nurses, is evident from this quotation. The nurses were encouraged to think of themselves as qualitatively different from their uneducated kinsfolk and neighbours. The idea was impressed upon them that their task was to uplift and educate, as well as to nurse, the members of their own (racial) communities. The nurses' own identification was with the educated, the western -- not the primitive and traditional. First their mission schooling, and then their nursing training, removed them from their own cultural background(s) to a great extent, and aligned the nurses with the culture(s) of the West.

Partly because the nursing profession was opened to Africans slightly later than was teaching[1], and partly because of the practical nature of nursing skills, nursing was <u>initially</u> considered good enough only for those girls who were not regarded as sufficiently intelligent to teach[2]. By 1920,

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[1] Searle (1965:269) states that, in 1910, there were 3 446 "Bantu Primary School Teachers" in the Cape, and one registered nurse, Cecilia Makiwane.

[2] McCord (McCord and Douglas, 1951:186) says of one of the first group of student nurses (who started in 1910) at the Mission Nursing Home:

> "Her father, far from objecting, remarked grumpily (of his daughter's proposed choice of career) that his daughter was too stupid for anything else".

PLATE III.

(a) The Assistant Matron's morning ward round: the matron (second left) checks treatment records with the student nurse (extreme left) who is dispensing drugs.

(b) The McCord Hospital choir, composed of student nurses, leads the singing at the annual Nativity Play. The choirmaster is one of the hospital doctors.

however, the idea that nursing could be a reasonable career, was becoming established:

> "So many native girls were now eager to become nurses that we could select only the best..." (McCord and Douglas, 1951:232)

More and more Africans entered nursing, although the overall numbers, especially of registered nurses, remained small. In the nineteen-thirties, the expansion became more noticeable. The second World War underlined the usefulness of the nursing profession, and enhanced the status of nurses considerably. Immediately following the war, the critical shortage of both European and African nurses in South Africa, resulted in improved conditions of training and service in the government hospitals, and increased pay. All of these factors combined to improve the status of the nurse (in both European and African communities) and over time, a career in nursing came to be regarded by African girls as preferable to teaching (which, until very recently, was the only alternative).

The Quest for Professional Autonomy.

In the early years of the twentieth century, there arose among European nurses in South Africa, a movement designed to free the nursing profession from the statutory control of the medical profession, and for nurses to assume responsibility for nursing affairs. This movement was not unconnected with the women's rights movements of the years following the first World War. Ironically, the person who was primarily responsible for the formation, in South Africa, of an association intended to achieve such professional autonomy for nurses, was himself a man and a doctor! It was largely through the efforts of Dr. John Tremble that the South African Trained Nurses Association (S.A.T.N.A.) came into existence, in 1915. This body successfully sought affiliation with the International Council of Nurses (which was formed in the

closing years of the nineteenth century), in 1922.

Registration as a trained nurse was still voluntary at this time, but only registered nurses were admitted to the S.A.T.N.A. In the late nineteen-twenties, however, when African registered nurses, who were eager to participate in the affairs of their profession, sought admission, they were refused. Consequently, in 1932, these African nurses formed their own Bantu Nurses Association. Because there were so few qualified African nurses at this time, admission to this association was thrown open to nurses who had only a hospital certificate, as well as those nurses and midwives who were registered with the Colonial Medical Council. The formation of the Bantu Nurses Association was an early indication of the distinct identity of African nurses. It is tempting to speculate that this formal association, which was affiliated to the White South African Trained Nurses Association, was one of the factors which led to nursing becoming a more popular career choice than teaching, among African girls. Certainly such an association could have been regarded as status-enhancing, in a society where contact between black and white persons was restricted, and where Europeans were regarded as having the "higher civilisation".

Initially, the European nurses' agitation for their professional autonomy, had little success. The Medical, Dental and Pharmacy Act of 1928 made provision for two representatives of nursing interests (either doctors or registered nurses) to be elected to the Colonial Medical Council, and to have full voting rights only on matters affecting nurses. But dissatisfaction and agitation continued, culminating, in 1942, in an attempt to establish a trade union for nurses. Trade unionism in nursing was averted by the hasty passage, through the Legislative Assembly, of the Nursing Bill, which became law a mere fifteen months after its first reading.

Legislation Affecting the Nursing Profession.

(a) The 1944 Nursing Act.

In terms of this Act (number 45 of 1944), the control of nursing affairs passed from the Colonial Medical Council to two entirely separate, official organisations, the South African Nursing Council (S.A.N.C.) and the South African Nursing Association (S.A.N.A.), both of which were created *de novo*.

The South African Nursing Council assumed most of the functions concerning the nursing profession, which had previously been held by the Colonial Medical Council. It is concerned with the protection of public interests and the maintenance of professional standards in nursing practice. The S.A.N.C. may take legal disciplinary action against members of the nursing profession whom it finds guilty of malpractice. The S.A.N.C. also prescribes syllabi for the various training courses, and conducts examinations; approves and inspects training institutions and their facilities; and maintains registers for students as well as trained nurses. The 1944 Act provided for the compulsory registration with the South African Nursing Council, of all qualified, practising nurses, on a single register, regardless of racial or other considerations. And in terms of this Act, *any* nurse might be elected to serve on the Council, provided she was fully trained and registered.

The South African Nursing Association, which is concerned primarily with the interests of nurses themselves, has a function complementary to that of the South African Nursing Council. The South African Nursing Association is the only official organisation of nurses in South Africa, and compulsory membership of this organisation is legally enjoined on all practising nurses. Thus the creation of the S.A.N.A. entailed the incorporation of members of

the older South African Trained Nurses Association and the Bantu Nurses Association, as well as those nurses who had not bothered to join these associations. South Africa is the only country in the world where membership of a professional association designed to protect the interests of the nurses themselves, is legally enjoined on all practising individuals.

The South African Nursing Association is concerned with nurses' working conditions and salaries; with promoting further study in the field of nursing by awarding scholarships and bursaries for post-basic study; and with effecting communication between widely dispersed members of the nursing profession, by means of the monthly publication of the South African Nursing Journal (in which papers and official notices are published and vacant posts are advertised). In terms of the 1944 Act, the South African Nursing Association was to be served by a Board of elected representatives, whc might be of any race, creed or nationality, provided that they were trained and registered nurses.

The non-discriminatory provisions of the 1944 Nursing Act drew nurses of all races into much closer association than had formerly been the case. Not only did one professional association replace two, not only were all nurses registered on the same register, but this was actually legally compulsory. In theory -- although this never happened in practise -- an African nurse could have been elected to serve either on the South African Nursing Council, or on the Board of the South African Nursing Association. The pace of development of African nurses in particular, and the necessary co-operation and collaboration on an interracial basis, proved unacceptable to many White nurses.

> "When the Nursing Bill of 1943 was rushed through Parliament, sufficient attention had not been given to this question...

> of a non-White nurse in a quasi-judicial role in disciplinary or ethical matters...There were many nurses who believed that the hard-won professional status and statutory responsibility could be jeopardised by exposure to professional immaturity and inexperience and widely divergent cultural concepts." (Searle, 1965:234, 235)

The contrast between the attitude described in this quotation, and the attitude of the missionary organisations mentioned previously, is quite evident. While certain people, such as the missionaries, were striving to align African nurses (and other educated Africans) with the culture(s) of the West, the majority of South Africans were not prepared to concede that this was desirable, or even possible. Such persons were, in effect, not prepared to recognise the "proto-elite" status of their African colleagues, and it was only five years after the triumphant passage of the 1944 Nursing Act into the statute book, that the first rumblings of discontent, which pertained to the non-discriminatory nature of this legislation, were heard. In 1949 (the year following the advent of a Nationalist government), a move for the amendment of the Nursing Act was tabled in the Legislative Assembly, but was shelved in favour of more "urgent" legislation[1]. Two years later, in 1951, a referendum was conducted by and within the South African Nursing Association, on proposals to limit the membership of the S.A.N.C. and of the Board of the S.A.N.A., to Europeans only, in law[2]. The move for amendment culminated in the Nursing Act (Amended), number 69 of 1957. The provisions of this Act extended the policy of separate development, or apartheid, into the nursing profession, and went far beyond the proposals approved by the slender majority in the 1951 referendum.

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1 Horrell, M. (compiler) Annual Survey of Race Relations, 1949-50:35.

2 See Jarrett-Kerr (1960). Chapter four deals with this period of nursing history (which is virtually ignored by Searle, 1965), in some detail. In this referendum, of a potential total of 9 866 votes, only 2 526 were actually cast: 1 422 were in favour of and 1 104 were against these proposals.

(b) The 1957 Nursing Act (As Amended).

The result of this Act was to separate nurses on the basis of their racial classifications, in distinct contrast to the provisions of the 1944 Act, which, as has been shown above, drew all nurses together in their profession, regardless of differentiating characteristics such as race or nationality.

Within the framework of the South African Nursing Council, the 1957 Act provided for the maintenance of three separate registers for each nursing qualification (that is, general nursing, midwifery, mental nursing, etc.), for European; Coloured and Indian; and African nurses. The single register that had been in operation since 1892, was thus fragmented by the 1957 Act. Furthermore, this Act gave the South African Nursing Council the authority to prescribe different syllabi for the different racial groups, at its discretion (which provision, up to the present time, has not been used). Finally, the S.A.N.C. was made responsible for an additional type of nursing training, the Auxiliary training, which (as mentioned previously) is of shorter duration than the general training and is geared to provide nursing personnel to undertake routine, practical nursing tasks. In line with the 1951 proposals put to members of the South African Nursing Association, the potential composition of the South African Nursing Council was altered in law, membership of the Council being restricted to Europeans only. Representation of the interests of non-European nurses was catered for by the introduction of two Advisory Boards, one for Africans, and one for Coloureds and Indians, with which the single European representative of each non-European group (on the Council), was expected to liaise.

The effects of the 1957 Act on the South African Nursing Association,

were similar. Membership of the Board of the Association was restricted to European nurses, and Advisory Committees were created to tend the interests of the other two groups. These Advisory Committees, again, liaised with their European representatives on the Board. Thus direct representation of non-European interests on the South African Nursing Council or on the Board of the South African Nursing Association, became a legal impossibility. Moreover, professional gatherings and meetings of nurses under the auspices of the South African Nursing Association, became racially differentiated as well. Even the biennial congresses of the S.A.N.A. were triplicated, thus restricting professional as well as social interaction between nurses of different races. Formal communication between nurses who belong to different racial categories, is thus effected only through the executive members of the Board of the South African Nursing Association, since they alone deal with all three groups.

However, despite the diminution of both professional and social contact between nurses having differing racial identities, as a result of the 1957 Act, the previous thirteen years of close formal association, and the still-existing links of all nurses to the (differentiated) framework of the South African Nursing Association, nevertheless involve a far closer rapprochement of Africans and Europeans in the nursing profession than in other professions, such as teaching, in South Africa. (The medical profession is, perhaps, still an exceptional case.)

The structural changes in the formal organisations serving the nursing profession, which were a result of the 1957 Act, were considered by many nurses to be contrary to the ethics of nursing. Discrimination on the basis of race, nationality, colour or creed, is explicitly rejected in the various nursing pledges taken on entry to full membership of the profession. Such discrimination is sufficient cause for membership of the International Council

of Nurses[1] to be refused or terminated, and some South African nurses sought the expulsion of the South African Nursing Association from the International Council of Nurses, on the grounds of the discriminatory character of the 1957 Act. The Federation of South African Nurses and Midwives (F.O.S.A.N.A.M.) was established late in 1957, and sought affiliation with the International Council of Nurses, challenging the South African Nursing Association's right to membership on the grounds that it was condoning racial discrimination within the nursing profession, in South Africa. Although this challenge resulted in the South African Nursing Association receiving a severe reprimand (concerning the 1957 Act) and a warning about its future in the International Council of Nurses, its membership was not withdrawn. One may speculate, firstly, that had the international political climate of today (1971) prevailed in 1958, the South African Nursing Association would indeed have forfeited its membership as a result of the 1957 Act; and secondly, that the warning regarding South Africa's future within the International Council of Nurses, may help to explain the fact that an important provision of the Act -- notably differential training on a racial basis -- has never been utilised.

The Expansion of the Nursing Profession among Africans: Some Causes and Consequences of this Expansion.

I have already dealt with the gradual expansion of the nursing profession

[1] Membership of the International Council of Nurses is on an association, not individual basis, and only one association per country may be accepted for membership. Such membership is significant in that it confers international recognition of nursing standards in member countries. The International Council of Nurses is also the organisation through which qualifications may be recognised in countries other than those in which the qualifications were obtained. The benefits of membership are, therefore, considerable, and are appreciated fully by European nurses in South Africa, since there is considerable movement among nurses, from South Africa to other countries, and vice versa.

among Africans during the first half of this century. In the past two decades, however, the number of African registered nurses has increased phenomenally. In the last ten years alone, the numbers have nearly doubled, from approximately 4 600 in 1959 to nearly 11 000 at the end of 1969: of this latter figure, 9 112 were registered general nurses[1]. According to Searle (1965:276), this increase is a direct result of Nationalist government policy: African nurses are being trained to serve their own race group.

Although European registered nurses outnumber their African colleagues by more than two to one at present, it is interesting to note that there were nearly equal numbers of European and African students registered with the South African Nursing Council at the end of 1969. The increasing convergence in student numbers for these two groups, is shown clearly in table 2[2] and graph A (see page 52).

TABLE 2. Student registrations, European and African, with the South African Nursing Council, as at 31 December each year: 1960-9.

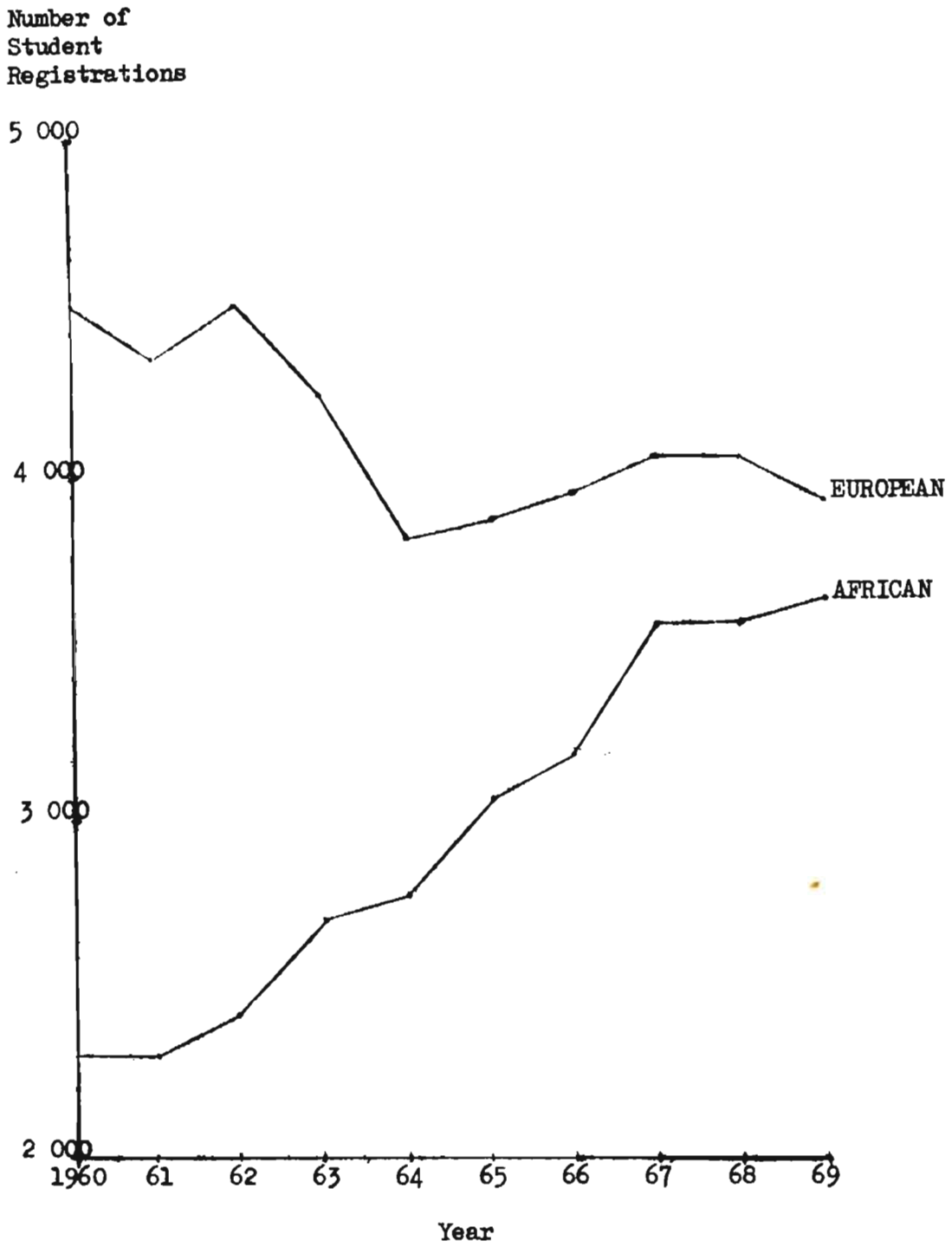
Year	European General Students	African General Students
1960	4 514	2 312
1961	4 344	2 309
1962	4 515	2 426
1963	4 243	2 700
1964	3 824	2 777
1965	3 870	3 045
1966	3 959	3 180
1967	4 061	3 567
1968	4 054	3 567
1969	3 938	3 635

These figures show clearly the extent to which the nursing profession

[1] There are other basic registrations, such as mental nursing, which make up the total: these figures have been supplied by the S.A.N.C.

[2] These figures have been extracted from the Report of the Fifth Council, S.A.N.C 1970, Annexure W, and pertain only to general nursing students.

GRAPH A.



NUMBERS OF STUDENT REGISTRATIONS, EUROPEAN AND AFRICAN, WITH THE SOUTH AFRICAN NURSING COUNCIL, AS AT 31 DECEMBER EACH YEAR.

(See Table 2.)

has opened up among the African sector of the population, particularly in the last ten years. The interesting question arises as to what effect this expansion has had on the position of the African nurse in her own racial community. Most of my informants who had trained in the late nineteen-fifties, mentioned the prestige associated with nursing, among Africans, at that time: many cited it as a factor influencing their own choice of career. Equally, most of this generation are adamant that the prestige associated with nursing has fallen since that time, and there are a number of indications as to why this might be so. I have no objective, scientifically-tested proof that the prestige of nursing has in fact declined among Africans.

The first factor that one should consider, is that the prestige arising from scarcity falls as more people enter a given occupation. Thus it would appear to be possible that, as the number of African nurses has increased, so the public esteem for their achievement has fallen. This in turn might be associated with a slackening of control over individual behaviour as the number of nurses has increased, with a corresponding decrease in feelings of solidarity among colleagues.

More important than this possible dilution of an elite group as it expands, however, are the factors associated with the 1957 Nursing Act (As Amended). Not only did this Act effectively sever the prestige-conferring contact African nurses had enjoyed with their White colleagues, it also conferred recognition upon a lesser type of nurse, the Auxiliary or Enrolled nurse. Where the lay public is not in a position to appreciate the differences between these two categories of nurse, the auxiliary draws prestige from the registered nurse, who, in turn, may be identified with the auxiliary. Because of her different and, in certain respects, qualitatively inferior, training, the auxiliary nurse (who has not undergone as intensive a socialisation

process as the registered nurse), is not subject to the same internalised control over her actions and behaviour. Nor, interestingly, is she subject to the same external control, since she is merely an "associate member" of the nursing profession. While there are few auxiliary nurses among White South Africans, there are over six thousand auxiliaries in the African population. Thus the official recognition of the auxiliary nurse has affected the status and prestige of the African registered nurse to a far greater extent than it has affected that of her European counterpart.

However, while these factors are quite apparent in explaining why it is possible that the prestige attaching to a nursing career may have declined among Africans, in the past decade, in the absence of conclusive evidence that it actually has declined, one must also consider the possibility that this postulated decline is merely a subjective opinion of older nurses. It may be part of the generalised feelings of superiority (or perhaps a reflection of feelings of inadequacy and consequent assertion of status?) of the older generation. The fact that the majority of my informants who believed that nursing had lost prestige in the eyes of the African population, were in the early- to middle-thirties age category, does not afford great support to this latter possibility.

Possibly the most credible explanation for this postulated loss of prestige, is that it is simply a reflection of a loss of prestige in the eyes of African nurses themselves: in other words, that nursing has lost some of its attraction as far as the nurses themselves are concerned, perhaps as a result of the 1957 Act. This explanation would appear to be logical, since it is obvious, from the figures in table 2, that the nursing profession has been attracting new recruits with ease in the past ten years. Presumably, if recruitment is easy, an occupation cannot have suffered too great a loss of prestige in the community at large.

A second major consequence of the deliberate expansion (in terms of government policy) of the nursing profession among Africans, is seen in the narrowing of the discrepancy between numbers of European and of African nurses, and particularly student general nurses. The trend towards converging numbers for these two racial categories, may well have caused unease in certain circles among European nurses: it is difficult to see how the present structure of Advisory Boards and Committees to cater for non-European nursing interests, can be maintained, let alone justified, should European nurses become a minority group in the profession as a whole. Given the rate of expansion of the nursing profession among Africans in the past ten years, and the figures for student registrations shown in table 2, it is not difficult to see that this trend could constitute a threat to the position held by European nurses at present. Certainly it seems somewhat paradoxical that the entrance requirements for general nursing students, were recently raised from the Junior Certificate to the standard ten level, when there exists an acknowledged shortage of nurses in South Africa[1].

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[1] In view of the ratio of 1:152, of European registered nurses to total European population (Report on Nursing Service in the Republic of South Africa and the Territory, 1970:5, table 2), it may sound contradictory to say that there is a particular shortage of European nurses. The shortage of European nurses, relative to the number of posts open to them, is, however, a result of the situation where many European nurses do not use their qualifications. The overall shortage of nurses has become so acute in Natal, that all nurses working in Natal Provincial Administration hospitals, will in future be paid overtime rates for work in excess of forty-four hours per week (see Daily News, Thursday, 12 August 1971). At present, registered nurses work a forty-hour week. Moreover, according to press reports, the possibility of using African auxiliary nurses in European hospitals, to relieve the shortage, is under serious consideration, especially by private hospitals. One of the effects of the revised regulations governing admission to training, will be a rapid increase in the numbers of African auxiliary nurses, of course, as well as a decline in the rate of increase in the numbers of African registered nurses.

Furthermore, O'Reagain (1970) has outlined proposals for the extension of hospital services by the Natal Provincial Administration. Ten new hospitals, with a combined total of some ten thousand beds, are planned to serve the African population of Natal. And O'Reagain (1970:176) states that:

> "It is intended that any deficiency in the number of nurses will be made good before all the hospitals are opened."

Recent Changes in Nursing Policy, and Some Probable Effects of these Changes, with Specific Reference to the African Population.

In November 1970, new regulations[1] governing the admission of prospective student nurses to the general training course, came into effect. In terms of these regulations, a prospective general nursing student must have a minimum educational qualification of the standard ten certificate, or else she must already be an enrolled auxiliary nurse. Previously, the Junior Certificate (standard eight level) was the minimum requirement.

In the final matriculation examinations at the end of 1968, less than two thousand Africans in the Republic of South Africa (including the Transkei) and South West Africa, obtained standard ten passes, and of this number, only three hundred and forty-two (342) were girls[2]. Thus it may safely be assumed that there will be a dearth of African applicants who may be accepted for the general nursing training, at least in the short- and medium-term future. This is particularly so in view of the fact that the small numbers of African girl matriculants have a fairly wide range of potential occupations from which to choose a career, and a course of university studies is usually of top priority for Africans in this position.

While it must be assumed that the new regulations governing admission to nursing training, have been brought into existence in an attempt to raise standards within the nursing profession, certain adverse effects may, perhaps, be anticipated, in view of the educational attainments of Africans at present.

"Table 2.4, in the section dealing with the educational level of students, shows how small the number of Bantu school

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[1] Proclaimed in the Government Gazette, 28 November 1969: no. 3792.

[2] Report on Nursing Education in the Republic and South West Africa, 1970:11, table 2.4,

> leavers is who attained the standard 10 certificate, with matriculation exemption (twelve school years) at the end of 1969. The number of these matriculants recruited for nursing training is not known."[1] (Emphasis supplied.)

In the light of this statement, there would appear to be two possible explanations for these new regulations. They may be the result of ignorance:

> "...based on a prideful -- and, in my view, unjustified -- estimate of the state of our country's medical and nursing services. We are not yet a fully developed country, for nursing services are notably uneven between city and country, and in fact, for the rural Black population, are sparse to the point of inadequacy."[2]

The second possibility is that this move to raise the entrance qualifications is a deliberate, if indirect, discriminatory move on the part of some European nurses, who feel that their position is somehow jeopardised by the increasing numbers of their African equals in the professional sphere. It may be assumed that these nurses have been supported, in all good faith, by others who are genuinely concerned with the raising of professional standards, particularly among European nurses, and with increasing the occupational prestige of nursing among Europeans in order to attract recruits of high calibre.

In the context of the South African situation as a whole, and of the 1957 Nursing Act (Amended) in particular, it is hardly surprising to find that African nurses themselves interpret the new regulations as a discriminatory move. It should be noted, however, that African registered nurses do admit that standards should be raised, particularly since few African trainees holding the Junior Certificate, have a good grasp of the English language,

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[1] Report on Nursing Education in the Republic and South West Africa, 1970:4 & 11, table 2.4. Incidentally, this table purports to give figures for the final examinations of 1968, not 1969.

[2] Personal communication from Dr. E. A. Barker: 14 September 1970.

which they are required to use during their training -- a failing usually attributed by African nurses to Bantu Education. The policy of raising standards is not questioned, but the apparent mis-timing of the introduction of the revised entrance requirements, is deplored, particularly by African nurses.

Certainly the likely effects of the introduction of these new regulations reverse, in some respects, previous policy in the nursing profession. For instance, where previously it was regarded as undesirable for a single hospital to run both general and auxiliary training courses, this situation has now become normal rather than exceptional. Non-European hospitals in particular, have been forced to establish the auxiliary course in order to ensure that the hospitals have adequate numbers of nursing staff, as well as to provide the possibility of producing some suitably-qualified applicants to undertake the higher level training in the future. Some hospital authorities, particularly of mission institutions, regard the continuation of the general nursing course as a matter of principle[1]. The smaller, rural mission hospitals have been affected most drastically by these new regulations, of course, and some of them face the possibility of having to abandon the general training. It is possible that some mission institutions see these regulations as an indirect attempt to restrict what influence they may have, particularly in the promotion of a non-racial society within South Africa. The large-scale bureaucracies of government and provincial hospitals operate within the framework of official policy: private mission hospitals have, in the past, been outside this field of control. How this situation will alter, following the assumption of financial responsibility for the majority of previously autonomous mission

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[1] This attitude is exemplified in the following extract from a personal communication from the medical superintendent of Victoria Hospital, Lovedale (formerly Lovedale Hospital):

> "We have been training African nurses for the same certificate as that awarded to European nurses since 1903 and it is our intention to continue to do so." (15 September 1970)

hospitals, by the Department of Bantu Administration, remains to be seen.

The single most obvious, and possibly most important consequence of these new regulations, will be a decrease in the growth of the number of African registered nurses, who are "full members" of the nursing profession, and who hold full voting rights in the South African Nursing Association. Correspondingly, there will be an increase in the number of African auxiliary nurses, who are "associate members" of the nursing profession, with no voting rights within the South African Nursing Association, at present. A proposal[1] to give auxiliary nurses voting rights, which was tabled at the 1970 Congress, was withdrawn at the request of the Board of the South African Nursing Association: this enforced withdrawal may, perhaps, be significant in the present context. Is the restriction on Africans attaining registration, and the expansion of the auxiliary category among Africans as a result of the revised entrance requirements, the means by which African nurses may be contained within the framework of the South African Nursing Association (thus ensuring continued South African membership of the International Council of Nurses) and yet not constitute a threat to the position of the European nurse -- at least in the foreseeable future? This is, of course, further speculation on my part, yet this interpretation does not contradict the available facts.

Paradoxically, however, despite the foreseeable negative effects of the revised entrance requirements for the general nursing course, on some non-European hospitals as well as African registered nurses, one effect of these regulations may be to raise further the status of the African registered nurse. As a result of these regulations, the nursing profession is being closed once more, at the higher level of qualification, in contrast to the expansion

[1] S.A.N.A. Resolutions for Discussion at the Biennial Congress for Bantu Members: B.C.B. 8 - 6/70; page 4, no. 13.

that has occurred during the past two decades. Thus the achievement of registration may be expected to become relatively less frequent among Africans, since the raised entrance requirement may make the general nursing course, leading to registration, almost as difficult to enter as the newer professions (such as physiotherapy and radiography) and the universities. This situation can only raise the social standing of the African registered nurse, especially among the African population. The process of closure may be expected to reinforce and even intensify the elite nature of the nursing profession among Africans. The social influence and leadership potential of the African registered nurse may thus be expected to increase as well. Developments in the nursing profession in the past decade do not contradict Jarrett-Kerr's earlier (1960:121) opinion that "...few people are more important on the seething continent of Africa than the African nurse".

In this chapter, I have tried to show the gradual processes, in South Africa, whereby African nurses have attained such importance. In the following chapters, I intend to examine some aspects of the nurses' elite status (resulting from their professional identity), and the effects that this status has on their social, kin and marital relationships.

CHAPTER FOUR

ELITE DIFFERENTIATION: NURSES AND NON-NURSES

There is one common view which holds that, in most societies, women especially are the conservers of tradition and the opponents of change. A contrary opinion has, however, been put forward by Brandel (1962:220), who suggests that, in situations of contact with Western cultural ideas, women in small-scale societies can sometimes gain more from modernisation than can their menfolk. For women, modernisation can lead to leadership opportunities, for instance, whereas for men, it often means restriction, even loss, of their traditional domestic rights. This suggestion may well explain why, in certain countries, African women have been reported to be more anti-traditional in attitude, than the men (Omari, 1960:208). And as could be expected, the rejection of traditional values and behaviour appears to be most marked among educated women.

The idea that women may benefit from modernisation, possibly at the expense of men, has been pursued by Banton (1967:186), who suggests that, in countries where Whites control racial hierarchies, the subordination of non-White men permits non-White women to seize greater domestic authority, and may thus give rise to the phenomenon of "matrifocality". It would also appear that women of subordinate races are regarded as constituting less of a threat to the position of the dominant race, than are the men. One should, then, see the expansion of the nursing profession among Africans in South Africa, in the light of the fact that African nurses are mostly women[1]. For whereas professional opportunities for African men in South Africa have been relatively restricted, Searle (1965:276) asserts that:

[1] There were 93 African male registered nurses in South Africa at the end of 1969: figures supplied by the S.A.N.C.

> "No single factor contributed more to the rapid development of the non-White nursing services than the policy of separate development."

Perhaps the government policy of training and employing increasing numbers of African women teachers, reported by Kuper (1965:172-3), affords further support for Banton's point.

While it is possible that a "White supremacist" situation may work to the relative advantage of women belonging to subordinate, non-White racial strata, the commitment of educated African women themselves to modernisation, is most important in the development of elite values. In addition to these two factors, however, there are elements in the structure of the nursing profession itself, which contribute to the overall elite status of African nurses in South Africa. I shall discuss some of these structural features of the nursing profession in relation to certain of the defining characteristics of elites, outlined initially in chapter two.

Firstly, the nursing profession is closed, and this closure has resulted in nurses forming a clearly identifiable collectivity. Admission to this closed profession is regulated in three ways: a minimum educational standard is demanded before a prospective nurse may be accepted for training; a protracted period of time must be spent in acquiring the skills specific to this occupation and, at the end of this period, competence must be demonstrated in both practical and written examinations; and, finally, the person who has fulfilled these two preliminary requirements, must be registered with the official professional body (the South African Nursing Council), before she may practise as a nurse without fear of legal prosecution. However, even though there are these three distinct restrictions on admission to the closed professional group, it must be noted that anyone may try to attain these requirements: the professional identity is achieved, not ascribed.

In addition to the formal closure of the nursing profession by its controlling authority, however, the removal of student nurses from the wider society (they live in a nurses' residence while training, and associate with few people outside the hospital "world"), leads to an awareness of their own separation from ordinary society. With this awareness comes identification with others in the same situation. Nurses, whatever their race, nationality or religious affiliation, are very much aware of their identity as nurses. In part, this identification stems from the system of ethics inculcated into nurses during their training, for the ethical code lays down certain behavioural expectations to which nurses are expected to conform. The various nursing pledges, recited at graduation ceremonies, embody these expectations.

> "I solemnly pledge myself to the service of humanity and will endeavour to practise my profession with conscience and with dignity.
> I will maintain by all the means in my power the honour and noble traditions of my profession.
> The total health of my patients will be my first consideration.
> I will hold in confidence all personal matters coming to my knowledge.
> I will not permit considerations of religion, nationality, race or social standing to intervene between my duty and my patient.
> I will maintain the utmost respect for human life.
> I make these promises solemnly, freely, and upon my honour."[1]

Insofar, then, as the ten thousand-odd African registered nurses in South Africa, are part of a collectivity closed by professional requirements, and are aware of themselves as a distinct occupational group, they may be regarded, in a preliminary way, as part of the African elite. In a previous chapter, I have discussed the development of the nursing profession among Africans: it is now necessary to see nursing in relation to other occupations open to Africans in South Africa.

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[1] The International Council of Nurses Pledge, reproduced here, is probably the most widely-used nursing pledge in the world.

Occupational Opportunities for African Women in South Africa.

Career opportunities for African women are limited, but expanding. Today the potential career choice open to African women includes teaching, nursing, physiotherapy, radiography, social work, general secretarial duties, even graduate research work and university lecturing. All of these occupations, each of which requires a recognised and lengthy training, obviously carry greater financial remuneration, prestige and job security than do domestic service, menial office jobs, or factory work, which are the alternatives to a professional training and career. In the past, however, the career choice was limited to nursing and teaching. While teaching was the first professional occupation opened to African women, nursing gradually became the more popular career choice, as a result of higher salaries, the predominant identification of nurses with an urban way of life, and the increasing numbers of nurses.

There are some obvious material advantages attached to the nursing profession, as opposed to teaching, for African women. During her three-year training, the student nurse is paid, housed, fed and supplied with free uniforms and shoes. The trainee teacher, on the other hand, pays for her tuition and all of her clothing, and although she may be housed and fed in a boarding hostel, the conditions under which she lives are likely to be less favourable than those of a nurses' home. Furthermore, job security is greater in nursing than in teaching, especially for the married woman, since the married teacher is declared redundant as from the date of her marriage. Even maternity leave is allowed for the nurse: the Natal Provincial Administration, for instance, allows registered nurses two periods of six months each for (unpaid) maternity leave, while holding the nurse's post open for her return[1]. In terms of working conditions, the nursing profession is more attractive

[1] The nurse can also claim unemployment insurance during maternity leave.

than teaching, even though the actual work may be regarded as being mentally less demanding and physically more taxing.

Moreover, the trained nurse will not usually be posted to "raw" country areas, as the teacher often is. And in terms of career potential, the registered nurse holds a qualification that is recognised internationally. Below the graduate level, African teaching qualifications in South Africa do not carry the same international recognition. In addition to the identification of African nurses with nurses in other countries, there is also the factor of relatively close association with European nurses (and doctors) in South Africa, whereas teachers of different races are not linked in a common professional association. Finally, and perhaps crucially, there is a good deal of prestige attached to hospitals and hospital work, by the lay African population, and thus, for African girls, "...nursing is probably the most popular professional career" (Preston-Whyte, 1969:24-5)[1].

Given the advantages of nursing over teaching, it is not surprising to find rivalry between African nurses and teachers, for nurses regard themselves as being socially superior to teachers, who resent this attitude. Each professional group holds certain stereotypes of the other, usually derogatory. Nurses regard teachers as being conservative, not sharing the same western-based value system to the same degree as do the nurses themselves. At the same time, they pity those teachers who have to teach and live in rural areas, divorced from the company of other educated people in the general community. Teachers, on the other hand, regard nursing as "dirty work", and see nurses as being unwarrantedly snobbish in view of the work they do. Nursing is regarded as mentally less demanding than teaching, and nurses themselves are

[1] In passing, it should be noted that the prestige attaching to nursing would appear to be much higher among Africans than among Europeans in South Africa, and this differing prestige rating is quite obviously related to their differential career opportunities.

stereotyped as being concerned only with their appearance.

Despite this occupational rivalry between nurses and teachers, however, a teacher may be instrumental in helping a schoolgirl to decide on nursing as a career. Especially where hospitals draw significant numbers of their students from particular schools[1], teachers may play an important part in advising suitable students of the merits of a nursing career. One suspects that European teachers have, perhaps, been more important than Africans in this respect, but nevertheless, African teachers are well aware of the objective advantages of nursing. Indeed, nearly ten per cent (22 of 226) of the registered nurses who responded to my research questionnaire, had themselves qualified as teachers prior to entering the nursing profession. (I am not aware of any similar but reverse trend -- of registered nurses re-training as teachers.)

The relationship between African nurses and African teachers may be interpreted in the light of their competing interests within the elite stratum: nurses and teachers may, in some respects, be regarded as rival elites. Tensions in the relationship arise from jockeying for prestige, and it seems that South African circumstances have favoured the nurses at the expense of the teachers, at least in the present. But although internal divisions along occupational lines do exist within the elite stratum, such relatively minor differences are ignored by nurses when they consider the structure of African society as a whole. Within the African population, the most important distinction, particularly in social terms, is found between the educated and the uneducated. "Educated" and "uneducated" are basic social categories in modern African society.

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[1] The McCord Zulu Hospital, for instance, draws approximately one-third of its students from Inanda Seminary, as a result of the historical link of both of these institutions to the American Board of Missions.

Bases for Social Categorisation among African Nurses.

(a) Friendship.

In general, African nurses identify with others who are educated, regardless of occupation: as one nurse[1] put it, "...we do not associate ourselves with the people". However, within the elite stratum, nurses stress their identity as nurses, and this emphasis on their identity as nurses (rather than as educated people), is reflected in the friendships they form. These friendships are usually restricted, both numerically and within the professional category, and often cross-cut ties based on tribal identity.

The patterns of friendship among elites are important. As Jacobson (1968:125) states, with specific reference to Mbale (Uganda):

> "...friendship with other elite Africans is critical in differentiating elite from non-elite...Friendship defines a major boundary, in ideology and practice, of the elite social system."

The factor of geographical mobility, of course, has an obvious and important bearing on the formation of friendships. When an individual has moved away from family connections, and kinsfolk are simply not there to draw the individual into the kin network, non-related friends must provide the framework within which much social interaction occurs. And while it is a truism that friends are selected, whereas kinsfolk are "ascribed", the strength and importance of friendship ties do reflect the cleavage, in contemporary African society, between elite and non-elite. African nurses are linked to non-elites by (among others) ties of kinship, but they seek and find satisfying social interaction with friends of elite status comparable to their own.

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[1] A delegate to the 1970 Congress.

Perhaps one of the reasons why friendships are so important to African elites, lies in the fact that the obligations of friendship are usually less onerous than those of kinship. African nurses, for instance, call upon friends to assist them in everyday difficulties. This assistance may range from borrowing baking pans to combing out tightly-plaited hair; or from buying a few items at market to advancing a short-term financial loan, but such aid does not involve any financial outlay that is not expected back in the short-term future. Kinship obligations, on the other hand, usually do involve non-returnable (and sometimes non-reciprocal) financial outlay, particularly when educational responsibilities are involved. However, the single most important obligation of friendship, as far as African nurses are concerned, is the holding in confidence of a friend's private and personal affairs, the ability not to "blab" to others[1].

African nurses do not form many friendships, but those that they do form are almost exclusively with other nurses. In fact, from informants' statements, it appeared that persons who were regarded as the closest friends of all, were often working at different hospitals, sometimes resident in different towns, who saw each other perhaps once or twice a year. Very often such close friendships existed between nurses who had been students in the same training group, and who had long since gone their separate ways, while the friendship itself had been continued over the years by correspondence and occasional holiday visiting. Perhaps one reason for the somewhat paradoxical closeness and durability of such friendships, lies precisely in the fact that the two individuals involved are <u>not</u> interacting in face-to-face relations, except on infrequent and irregular occasions. Both persons have, therefore,

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[1] Vilakazi (1965:139) notes the stress on "privatism" found among those he terms elites (including nurses), in the rural Nyuswa area. "Shouting" (that is, making one's affairs public) is looked down upon by Christians, who regard it as typical pagan (and, therefore, uneducated) behaviour.

far greater control over this type of relationship, than either has in her relations with colleagues and others, with whom she is constantly interacting. The possibility of conflict arising and splitting the relationship, is thus reduced to a minimum in the situation where friends are separated geographically. In this context, it is significant that visiting, on a purely social basis, is restricted among African nurses, except between those who are very close friends: privacy is highly valued.

Thus friendships among African nurses not only differentiate elites from non-elites: they also stress the identity of nurses within the elite stratum. Nurses may be acquainted with teachers, may even interact with them on a fairly regular basis, but they do not regard teachers as friends. Nor, necessarily, do they regard all colleagues as friends, although friendship normally tends to be restricted to co-members of the nursing profession, and thus emphasises the occupational (and social) boundary separating nurses from non-nurses.

(b) Life Style.

If friendship is one index of the differentiation of elites from non-elites (and, therefore, a basis for social categorisation), life style is another such index. Life style is, of course, closely related to income, and educational, occupational and financial differences between elites and non-elites are reflected in their different standards of living.

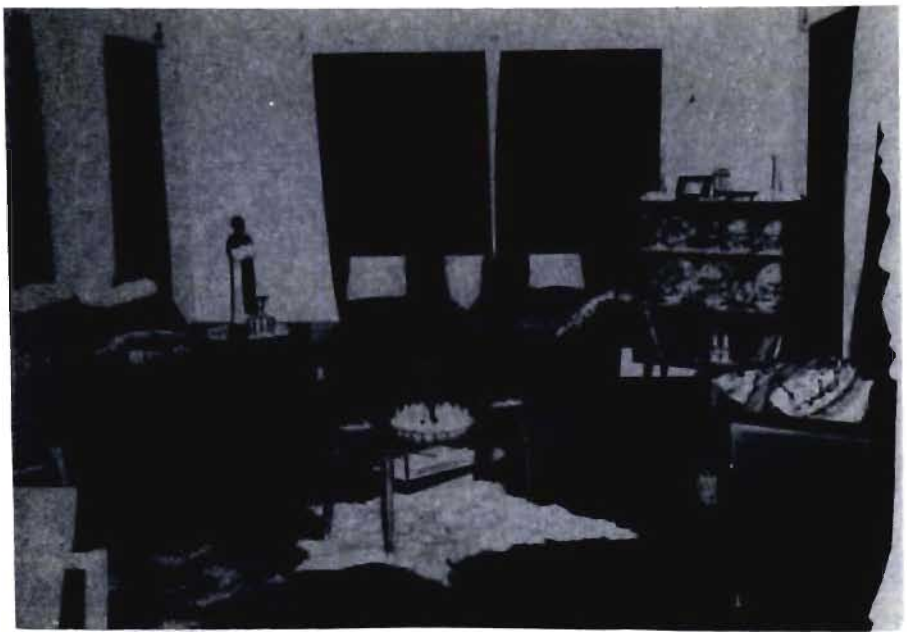
The material rewards accruing from the African nurse's professional occupation, are considerably less than those accruing to her equally-qualified European counterpart, but are nevertheless sufficient to allow her to live in a style markedly different from that of the ordinary labourer, or unskilled

African worker. The material trappings of the nurse's social status are the prime focus for imitation by others, and it is partly these material possessions which give rise to the deference and respect which the African nurse is accorded.

Members of African society who live in a manner that can only be designated as "western" or "modern", provide the image of progress to other Africans in South Africa. Nurses, among others, provide such an image. Their homes, whether these are privately constructed or merely "improved" township houses[1], all reflect the relative financial well-being of the nurses and their families. The walls are plastered and painted; the kitchen is tiled; the floors may be parquet- or marley-tiled, or even carpeted; all rooms have doors, or some other means of ensuring privacy; where cables permit, electricity will have been installed. In these homes, the furniture is expensive -- lounge, dining room and bedroom suites, carpets and rugs, refrigerators, stoves, electric kettles and irons, bedside lamps, display cabinets, and so on. Virtually all such furniture, it must be noted, is acquired through hire purchase accounts, and it is highly doubtful whether nurses and their families (and other African elites in South Africa) would be able to maintain their present standard of living, were they not able to utilise this type of credit facility. The apparent ease with which nurses use hire purchase facilities may well, in itself, be a specific indication of their elite status, recognised in this way by the (European) firms with which they deal. Of course, not only nurses live in the manner described above. But the difference between the homes of nurses and those of other (aspirant) elites, is that the nurses <u>live</u> in their homes. Their homes do not have

[1] Township houses, having either two or four rooms, are constructed <u>en masse</u> and sub-economically by municipal or government housing authorities. Usually the open brick is not plastered; the floors are merely concrete slab; there are no internal doors -- the house is merely a shell, for shelter. Any and all improvements must be financed by the tenants or purchasers, who are re-imbursed for improvements when the house is resold. (It must be resold to the township authorities in the initial instance.)

PLATE IV.



(a) The lounge of a privately-built home belonging to a nursing sister and her husband, exemplifies elite living standards.

(b) Having completed her work for the morning, the maid relaxes in the kitchen of a staff nurse's home.

expensive furniture in every room, while the family virtually lives in the kitchen, a situation I have witnessed in the house of a successful trader married to an ex-teacher, for example. As one of Brandel-Syrier's informants notes:

> "'A house is not everything; you must know how to live in it.'" (Brandel-Syrier, 1971:58)

Conspicuous consumption among elites has been noted in many parts of Africa, and to the extent that they regard it necessary to live in a manner befitting their high status, it is found among African nurses as well. In the African community, a member of the elite would lose status if he or she did not live in the manner expected by the rest of the community: this is probably true in most societies. However, the furniture and clothing (in terms of which conspicuous consumption is evidenced), bought by African nurses, is considered by them to be necessary for use, not for show as such. Elements of conspicuous consumption are far more evident among those striving to attain elite status, than among those who already have it. The elites use their possessions: the aspirant elites acquire similar possessions in order to lay claim to similar status. This policy of conspicuous consumption among aspirant elites reflects what Nadel (1956) terms the "imitability" of the true elites.

The imitability of nurses, as elites, is evident in more than their houses and furniture, however. Nurses are innovators in the realm of dress and fashion: as Kuper (1965:113) states, "African nurses, in particular, set an example in glamour and elegance". For instance, in Durban recently, Afro wigs have enjoyed increasing popularity since the introduction of this fashion by young staff nurses. Likewise, mini-skirts have been adopted by young, presumably urbanised, African girls, particularly office workers. However, nurses still have a virtual monopoly over the wearing of slacks and trouser

suits, at least in Durban, and this monopoly is related to values, for only those women who are committed to the "western way" would dream of wearing a type of dress traditionally (in western society, that is) the prerogative of men.

Beyond the realm of fashion, the leisure activities of nurses are also innovative, and provoke great interest in the African community. When a nurses' ball is held within hospital grounds, for instance, the doors must be guarded to prevent the mass entry of patients and domestic workers, who display tremendous interest in the proceedings. (I have witnessed such a situation at Nqutu, in rural Zululand, as well as in Durban.) Ballroom dancing, at which nurses excel, is, of course, an extremely prestigious leisure activity. But even handwork, especially crochetting, is closely associated with nurses as a group, and their example in this field is followed by, among others, domestic servants. Preston-Whyte (1969:312) states that:

> "Embroidery and crochet-work...were regarded as smart and indicative of a certain discernment and even, by some women, as a sign of respectability and what may be termed 'class'."

Thus nurses, as elites, set standards (of dress, housing, furnishing and leisure activities) that are imitable by other, non-elite Africans. As will be shown in a later chapter, these standards are not restricted to material possessions, but go further and involve attitudes and values, for the nurse regards it as her duty to "educate" the uneducated -- that is, to inculcate her own values into others.

However, while nurses are actively promoting change in African society, through their innovations, it must be noted that not all members of the African community accept their lead. Essentially, nurses, and other elites, divide their society into two sections, one of which finds their example

acceptable, and imitates it, while the other section rejects their innovations. As Nadel (1956:420) writes:

> "...when traditional and anti-traditional conceptions come into conflict...the existence of the elite...is proved when the 'new men' claiming pre-eminence in fact succeed in 'setting standards' accepted by others, and thus divide the society, if only for a period."

Thus the example upheld by the elites, is unacceptable to "traditionalists in Africa today, for their example is a rejection of traditional values and behaviour. For instance, nurses reject emphatically the idea of patrivirilocal marriage, and express a preference for small families, to which end they utilise modern contraceptive techniques: both of these practices negate traditional African values. However, even though part of the African population does not accept their lead, it seems that even the traditionally-oriented respect the elites, and adhere to general community expectations regarding elite behaviour, even though they do not aspire to follow the example set by the elites. Thus, although the elites are the standard-setters, they are, to some extent, bound to conform to community expectations, or else run the risk of losing prestige and status in the eyes of all, including the uneducated.

(c) Stereotypes.

A system of stereotyping, using what are ostensibly kinship terms, is applied by nurses to different sections of the uneducated stratum of African society. The stereotypes differentiate among sections of the uneducated masses, on the bases of age and sex.

Except for the very old (to whom the Zulu term gogo: grandmother is applied), uneducated or less well educated women are usually referred to as aunties. Any woman a nurse calls auntie to her face, will be older than the

nurse, though occasionally they may be of the same generation. Aunties are conservative in appearance and manner. The term auntie, from its English derivation, would appear, on the surface, to be respectful but time-saving, since it is used frequently in hospital wards and clinics, to patients. But despite its outward connotations of respect, auntie is applied to a category of people for whom the nurse has little time or respect, as is evidenced in the following quotes from informants.

> "The aunties wear these long skirts -- look, you can see them now (indicating through the window). You must wear a skirt at least down to here (indicating mid-calf) or they say you are very immoral! Mostly the aunties are raw people from the country. Even though they may be Christians, still they think as our people used to long ago...
> Now you see from what I am wearing today (a skirt and blouse of similar dark colours, though not proportions, to those worn by the group indicated), Thomasina (her staff-nurse neighbour) was teasing me that I must join the aunties!"

> "Auntie, you are much, much too fat. How many children? TEN?? (Turning to anthropologist) Hau! Aunties never learn! (at ante-natal clinic.)

The nurses' reaction to the aunties must be seen in the context of the nurses' adaptation to a culture that is anti-traditional. The nurse role has no place in traditional African society, and it is in the nurses' own interests, then, to avoid being identified with attitudes and values which belong in the traditional, or at least semi-traditional, setting. Such identification with traditional culture would detract from the elite status of the nurses: I have already mentioned that one of the nurses' reasons for regarding teachers as having a lower social status than the nurses themselves, relates to the teachers' (alleged) greater conservatism. However, it is also possible that part of the conflict between nurses and aunties, stems from the fact that they belong to proximate generations.

Aunties are, then, uneducated women somewhat older than the nurse who is

using the term. The corresponding term for men who are somewhat older than the nurse, is buti (from the Afrikaans boetie: little brother) or uncle, but neither of these terms is used with any frequency. In general, nurses seem to avoid calling uneducated men who are slightly older than themselves, by any term at all. However, an uneducated man who is considerably older than the nurse, will invariably be called baba (the Zulu term for father). The combination of age and masculinity appears to balance out lack of education, for nurses show deference to elderly, uneducated men, in normal circumstances. Perhaps this deference reflects the strength of the patrilineal idiom in Nguni society, even today.

The elderly woman (gogo), on the other hand, is regarded by the nurse with a mixture of deference and exasperation. Her age entitles her to respect, yet her lack of education, adherence to traditional beliefs and behaviour, and frequent refusals to follow the nurse's instructions, irritate the nurse in much the same way as do the aunties. Kuper (1965:224) quotes one nurse as saying:

> "'Uneducated women are the worst patients. If they are older than we are, they don't like us for telling them what to do, and if they are our age, they are jealous of our position.'"

It is perhaps significant that nurses apply stereotypes to uneducated people who are older than themselves, but that the younger generation of the uneducated stratum is not stereotyped (with the exception of the tsotsi's). Perhaps this age differential in stereotyping is a result of the ambivalence of the nurse's position with respect to uneducated members of older generations. As a result of her professional occupation, the nurse's social standing is higher than that of the aunties, gogo's, uncles and baba's. In terms of traditional expectations, however, the nurse is younger than these people, and her status should, therefore, be lower. The nurse reacts slightly differently,

then, to each of these sections of the uneducated stratum, according to the strength of their claims to deference from her, on the basis of age and sex. But as far as her own and younger generations are concerned, the nurse is superior in terms both of occupation and age. Only those uneducated young men, who challenge the nurse's claim to social superiority on the basis of her (traditionally inferior) status as a woman, are stereotyped as tsotsi's, "...'who respect nobody'" (Kuper, 1965:224).

I have shown, in these sections, how African nurses mark themselves off from the rest of the African population. Their friendships stress their elite identity and, more specifically, their identity as nurses within the elite stratum. Their life style and material possessions set them apart from the non-elites, who imitate them, to some extent. And the nurses' system of stereotyping and categorising various sections of the uneducated, non-elite masses, demonstrate, in some detail, how and why nurses differentiate themselves from particular sections of the uneducated African population. In the next section, I shall examine how this differentiation of nurses from both non-elites and non-nurses among the elites, operates within the context of membership of voluntary associations.

Association Membership among African Nurses.

During the course of my research, I gained the general impression that the majority of African nurses are not particularly interested in joining clubs and societies, although I cannot support this impression with detailed statistical data. However, only a small proportion of nurses are actively involved in the affairs of the local branch of their professional association; fewer still belong to sports clubs; and although the vast majority claim affiliation to an orthodox Christian church, relatively few are active in

church affairs either. The nurses' emphasis on their privacy is, to some extent, incompatible with widespread membership of voluntary associations: I shall return to this point later. However, even though there is relatively little active participation, particularly in the affairs of the professional nursing association and church activities, what one might term latent membership, or non-active affiliation, does reveal some important aspects of elite status. Thus active or passive affiliation to certain organisations, is significant.

(a) Professional Association: The Ogwini Branch[1].

In South Africa, it is legally obligatory for all practising registered nurses to belong to the South African Nursing Association. African members at present pay R6,00 per annum for their membership, which includes voting rights, and the South African Nursing Association has the necessary powers to sue any members who may be in arrears with their subscriptions. Furthermore, many hospitals, particularly provincial hospitals, demand proof of payment by submission of receipts, and in cases where these receipts cannot be produced, sanctions such as forfeiture of one's leave bonus, or even termination of employment, may be applied. But although nominal membership is thus enforced, active participation in the affairs of the South African Nursing Association, is voluntary, in the sense of being left to the individual's own discretion.

The local branches of the South African Nursing Association are triplicated along racial lines, and are all ultimately controlled by the S.A.N.A. Headquarters, in Pretoria, under the direction of the Chairlady, Organising Secretary and the Executive Board. Of some thirty-one African local branches, four are in Natal and Zululand, and these are based at Stanger, Dundee, Pietermaritzburg and Durban. The Durban-based Ogwini Branch stretches beyond the city itself, to include nurses working at all health institutions

[1] See Appendix III: "Procedure Adopted for the Ogwini Branch" (Constitution).

from Durban to beyond Port Shepstone, and inland to Botha's Hill.

The establishment and organisation of each local branch depends upon the members of the South African Nursing Association in that particular area. So the move to set up a local branch depends upon the initiative of nurses working in that area, and once the South African Nursing Association has approved the formation of a new branch, and the Organising Secretary has assisted in its inception, the running of the branch is the responsibility of the nurses themselves. Each branch elects office bearers at regular intervals, usually annually. The Ogwini Branch has an Executive Committee of eleven members, including the Chairman and Vice-Chairman, Secretary and Assistant Secretary. Three members of the Executive Committee are jointly responsible for financial affairs and may, at times, be controlling income and expenditure totalling many hundreds of rands (derived from concerts, picnics, jumble sales and other fund-raising activities), as happened when the Ogwini Branch organised the 1970 Biennial Congress for African members of the South African Nursing Association.

Belonging to such an association, which is effectively controlled by Africans, and yet has strong ties of affiliation with Whites -- and, therefore, official recognition -- obviously has elitist value, but this is tempered by South African circumstances. African nurses, especially those who are not actively involved in S.A.N.A. affairs, express antagonism to what they regard as a "stooge" organisation geared primarily to White interests. Perhaps this is inevitable in view of the overall structure of the South African Nursing Association, stipulated in the 1957 Nursing Act (As Amended). Bluntly, this negative attitude reflects racial antagonism, very often on the part of African nurses who have, in the past, been disillusioned with the apparent failure of the Board of the South African Nursing Association, to improve

conditions for African nurses. The following quotation illustrates this point:

> "We do not doubt your sincerity, but looking at the salary gap between the White and the non-White races, one tends to fear that one is seeing what one would not like to see: that the Board is 98% behind the other people, and maybe 2% behind the Africans.....Which of course is not so. But I am trying to show that, if one just looked at the figures, it would give that impression."[1]

The majority of African nurses who do not attend branch meetings, and who express lack of interest in the affairs of the South African Nursing Association, echo this attitude, rather more vehemently, and regard active support of their professional association as a waste of time in terms of results. But this is not the only reason for lack of participation. One cannot always be off-duty when meetings are held, and even when they are off-duty, African nurses (like other people) have multiple claims on their spare time, especially those nurses who are married and have families. Nurses in different age categories have differing leisure-time interests, and attending meetings is not usually a leisure interest of younger nurses. Finally, there is also the age-and-authority factor.

Respect for one's chronological seniors is important in African societies, perhaps more important than in most others; and the nursing profession itself is highly stratified on the basis of rank, which normally coincides with age grading. When a young African nurse is in authority over her rank juniors but chronological seniors, she is in a situation that is (at least potentially) tension-laden, because the expectations of her professional role conflict with those of her age. Within the all-African structure of the local branches of the South African Nursing Association, the positions of authority are held by the older generation of nurses, to a degree quite disproportionate to their numerical strength (or weakness) in the profession as a whole. Only 25,4% (57

[1] From a delegate's speech at the 1970 Biennial Congress.

of 226) of questionnaire respondents were over forty years of age, yet I knew of only one member of the Ogwini Branch Executive Committee who was under forty. In this situation, where authority in the affairs of the professional association, is vested in the older generation, few young nurses (who hold staff nurse or junior sister rank in the work situation) are interested in subordinating themselves to the senior generation of ward sisters and matrons, outside the work situation. These younger nurses prefer to spend their time listening to records, dancing, shopping, playing sport, going to the beach -- rather than attending meetings which usually last for at least three hours, and discussing matters which involve financial outlay for no readily apparent returns (such as donations in the name of the branch, financial support of retired nurses, and so on).

There is one other factor involved in the dominance of older and senior-ranking nurses in the affairs of their professional association, and this is the distinction that can be drawn between old and new elites. The older nurses belong to the generation having extensive and intensive contact with the missions[1]. They are mission-educated and, in the majority of cases, mission-trained as nurses, and perhaps they may be regarded as part of what Mercier (1956:448) has termed the "colonial elite". The younger nurses, on the other hand, have had a more protracted school education (in secular institutions) and a more modern training: they may thus be regarded as part of the "intellectual elite"[2]. Between these two sections of the elite stratum, in most occupations, there exist certain differences in interests and attitudes, which are related to the slightly different socialisation processes. Thus

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[1] The religious background of the Ogwini Branch organisers, is apparent in branch meeting procedure. Meetings are always opened with a prayer, in English, by a member.

[2] By "colonial elite" Mercier means those with post-primary education, who have stable and secure civil service positions. The "intellectual elite" comprises highly educated professionals, and has largely arisen since the second World War, in Africa. Conflict between the two often stems from the situation where the lesser educated "colonial elites" hold the higher posts, simply because they were available earlier, when the positions became available.

one finds, among nurses, that the older nurses have "stabilised" their position in society, since they do hold the posts of authority, and would appear to have lost much of their motivation to introduce change. On the question of salaries, for instance, the older nurses accept that government policy decrees differential salaries for Black and White, and while they are prepared to fight for better salaries within the Black scales, they are not prepared to risk their own positions by demanding parity in salaries, between Black and White, as the younger nurses do. This is not to say that the older nurses agree with the principle of differential salaries: merely that they stand to lose what they have achieved, and therefore do not support moves for radical change. The younger nurses, on the other hand, dismiss the policy of gradual change, which is supported by the older nurses, as being unworthy of their support, since the results of gradual change are, for them, unsatisfactory.

Despite the general lack of support from African nurses, however, the activities of the Ogwini Branch show concern not only with professional interests, but also involve nurses in their relationship to the wider African community. The African nurse, through her membership of a common professional association with Whites, has the possibility of using this position to improve both her own position and conditions within the African community. Some of the resolutions tabled at the recent nursing congress illustrate this attempted manipulation of professional ties, for ends that are not strictly professional. It was proposed:

> "That the Board of the Association be asked to assist nurses in installing telephones in their homes."
>
> "That the Board of the South African Nursing Association makes representations to the authority concerned to relax the regulation whereby the homes of widowed and divorced nurses are repossessed in townships governed by township authorities."
>
> "That the Board of the South African Nursing Association

> investigate the possibilities that nurses be exempted from curfew laws."

While these three resolutions are directly concerned with the elite interests and legal status of African nurses, even though they do not relate directly to professional issues, the following proposals have still wider referents:

> "That representations be made to the appropriate authorities for the establishment of crêches for the children of hospital employees."
>
> "That representations be made to the Department of Bantu Education for compulsory education to at least standard 6 for all non-White groups."
>
> "That representations be made for the establishment of special centres for the treatment of drug addicts and alcoholics."
>
> "That the Board of the South African Nursing Association make representations to the Department of Bantu Administration for the granting of rebates to Bantu tax-payers in respect of children and dependents."[1]

The use to which African nurses put their professional ties with their European colleagues, and particularly their membership of a common professional body, is thus quite evident. These links offer the possibility of occasional manipulation of the South African (White) bureaucratic structure, to the advantage of African nurses in particular, and the African population in general. In their role as initiators of this manipulation, the nurses stand to gain prestige. To the best of my knowledge, with the exception of the medical profession, there is no other occupation in which Africans have such possibilities for manipulating the controlling (European) professional authority, for their own ends or for the good of the community: for if nurses,

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[1] Resolutions for Discussion at the 7th Biennial Congress for Bantu Members of the S.A.N.A.: B.C.B. 8 - 6/70: nos. 3; 17.3; 17.4; 19; 21.6; 23; 25.

no matter what their racial classification, pass a resolution at one of these congresses, the Board of the South African Nursing Association is bound to act upon it.

Although most African nurses do not afford their professional organisation very much support in the normal course of events, they do, however, identify with large-scale activities of the local branch. During the period of preparation for the 1970 Congress, and at the Congress itself, active branch members could and did call upon the assistance of hundreds of nurses in the Durban area, most of whom would not support the branch normally, and who gradually dropped out after the Congress was over. Likewise, picnics at Umgababa (an African South Coast resort), and a visit, in uniform, to Kwa Magwaza, to attend a Nurses' Day church service (organised by the North Coast branch), were also well attended. The most obvious reason for this identification with the professional nursing association for public and even ceremonial occasions such as these, lies in the prestige accruing from such public events, which receive newspaper coverage, even in the European press, on occasion. Such support in the face of publicity, must be regarded partly as an assertion of status, whatever other factors may be involved.

The professional association is thus partly responsible for the nurses' elite status within the African community, and this status is reinforced periodically by public gatherings of African nurses, of the type mentioned above. But the identification of African nurses with their colleagues is not restricted to activities of the local branch of their professional association: it is also demonstrated in their membership of other voluntary associations, especially church groups.

PLATE V.

(a) An exhibition of handwork at Clairwood Hospital shows why African nurses are renowned for their skilled crochet-work.

(b) Durban, 1970: delegates to the Seventh Biennial Congress for African members of the South African Nursing Association, listen attentively to a guest speaker.

(b) Religious Affiliation.

In common with other educated African elites, nurses belong almost exclusively to orthodox Christian denominations. Most belong to African branches of European churches. Some belong to African churches that are now independent of their parent mission bodies, such as the United Congregational Church, which was originally part of the American Board of Missions. These independent churches remain orthodox in creed and ritual, however. Only a tiny minority of African nurses belong to unorthodox, separatist churches and little-known sects. As may be seen from table 3, nearly 78% of the questionnaire respondents (176 of 226), belonged to the four major denominations of Catholic, Methodist, Anglican and Lutheran, this affiliation being partly related to their missionary educational background.

TABLE 3. Religious affiliation among African registered nurses[1].

Catholic	56
Methodist	51
Anglican	44
Lutheran	25
*United Congregational	17
Presbyterian	7
American Missionary Board	5
*Bantu Methodist	2
*Bantu Presbyterian	2
Dutch Reformed	2
Baptist	1
Church of Paris Mission	1
Congregationalist	1
Full Gospel	1
*Assemblies of God	1
*Church of God of Prophecy	1
*Church of Zion	1
*Ethiopian	1
*Pentecostal Protestant	1
*Twelve Apostles' Church	1
Unknown	5
TOTAL:	226

[1] * indicates independent status.

This membership of churches linked both in origin and ritual to European organisations, is tacit affirmation of the point made in chapter two, that elite status rests largely on participation in the new, western-based, modern cultural system. Although African women normally assume their husbands' church affiliation after marriage (where this does not already coincide with their own), I know of one nurse who flatly refused to affiliate herself, even nominally, with the Zionist sect of which her husband was a (nominal) member. Since her husband refused to let her continue her former Methodist affiliation, this nurse attended no church at all rather than keep company with Zionists. Particularly telling, in terms of elitist values and behaviour, is the following quotation from one nurse on the subject of Shembe's church.

> "And the son...he has a B.A. degree, and look at what he is teaching the people. They pray to Shembe, not to Jesus... And the dancing and the beer-drinking! He is not educating the people. That is not progress. He is dragging them back to how the Zulus used to live. No, that is very bad, especially for an educated somebody."

The behaviour of Zionists, especially, is regarded as being unacceptable to a nurse, incompatible with her whole outlook. Not only is Zionist behaviour and religious interpretation regarded askance by nurses, but the fact that Zionists are thought of as uneducated and dirty, removes them from the nurses' potential sphere of social interaction. To associate with such people would cause gossip and detract from their high prestige. And, of course, the nurses' ideas on the subject of disease causation and healing differ radically from those of the Zionists (as well as those of many of the non-medical elites, one suspects).

Most orthodox African churches have <u>manyano's</u>, or Mothers' Unions, the equivalent of the European Women's Guilds. These organisations provide the means through which women may feel that they are playing a significant role

in the life of the church to which they belong. In the main, the women who belong to these manyano's are non-working wives, or perhaps they hold some type of unskilled or semi-skilled job, such as domestic service. They tend to have a fairly low standard of education, and some may be illiterate. They are conservative, both in behaviour and ideas. They are, in the nurses' terminology, the aunties, and a very clear distinction is drawn between nurses and aunties, as has been indicated previously. It is not surprising, then, to find that nurses, with very few exceptions, do not belong to the manyano's.

This is not to say, however, that many nurses do not lead actively religious lives. Probably the majority of them attend Sunday church services when they are free, and some of the provincial hospitals, as well as the mission hospitals, have regular chapel services conducted by visiting ministers of different denominations. Of those nurses who are regular church-goers, many deplore the fact that they "don't have enough time" to attend manyano meetings, which are usually held on Thursday afternoons -- admittedly a difficult time for most nurses to attend on a regular basis. However, I submit that this excuse based on lack of time, is often a front which conceals the nurses' unwillingness to put themselves into a position of equality with, or even subordination to, the aunties. Indeed, this is recognised and admitted by certain nurses who have considered the situation at length. The situation in the Catholic church illustrates the point.

Within the organisation of the Catholic church, the mothers are those who have a special dedication to St. Anne. The St. Anne group (manyano) in each mission centre, is organised under the leadership of a chairlady and secretary, plus other committee members, who are elected at regular intervals. Invariably, so Catholic nurses tell me, the people who are elected to these positions are aunties, and they are accorded great deference by the rank and

file members. As the nurses say, they are not prepared to "bow down" to these aunties, and so the nurse who belongs to the St. Anne's group is a rarity. None of the Catholic nurses I met, knew of any nurse who is a member of this group, although African teachers are, apparently, members.

However, nurses couch their reasons for not joining the St. Anne's group in terms of their limited free time. The woman who joins the St. Anne's group is required, apparently, to undertake certain vows, and the nurses say that they cannot commit themselves as strongly as these vows require, because they do not have the time. Therefore, they do not join the group. Instead, they are caught up in the activities of the Catholic Nurses' League, or Guild.

Significantly, in terms of time commitment, contributions and activities, there appears to be little difference between the St. Anne's group and the Nurses' League. Both are concerned with chasing up laggard Catholics, fund raising, doctrinal instruction, prayers and religious study. Members of both groups are expected to visit the sick, though this requirement is less strictly enjoined upon the nurses! The funds that both collect are used for charitable purposes, such as assisting destitute individuals and families with food, for short periods. Significantly, the nurses also use their "purse" to educate Catholic orphans, who are expected to repay the "purse" later[1].

The only real difference between nurses and aunties in their respective organisations within the Catholic church, is that nurses are not required to make any vows regarding their commitments. This may well be a result of the assumption that their social conscience, by virtue of their occupation, is more highly developed and less in need of spiritual reinforcement. In any case,

[1] The Ogwini Branch of the South African Nursing Association, has recently voted to "adopt", for educational purposes, a poor child in the Durban area, and finance that child through school until he/she obtains at least the Junior Certificate. Is this type of commitment to education another specific index of elitism?

both the establishment of a separate organisation catering exclusively for nurses, and the waiving of the vow requirement, are indications that nurses constitute a significant and even unusual group, and this concession on the part of a formal organisation as important as the Catholic church, is itself an indication of the nurses' elite status.

Whereas the Catholic church has made separate provision for nurses in organising formal women's groups, and has thus retained the nurses within the Catholic framework, other churches have neglected this approach. Consequently, nurses in the various Protestant churches, who are interested in active participation in religious associations, generally belong to the Young Women's Christian Association (Y.W.C.A.), which organises both social and religious functions from its headquarters in Beatrice Street, in the centre of Durban. Not only are dances, dancing classes, indoor sports and music evenings arranged under the auspices of the Y.W.C.A., but fund-raising for charitable, including educational purposes, is also important. Of the active members of the Ogwini Branch, particularly those belonging to Protestant denominations, many belong to the Y.W.C.A. as well.

(c) Other Voluntary Associations.

Apart from the professional and religious organisations discussed above, a few nurses belong to sports clubs. Those who do are mostly single and in the late-twenties to early-thirties age group. Almost exclusively, they belong to tennis clubs and, as Wilson and Mafeje (1963:125) note for Cape-Town:

> "Tennis is a game of the ooscuse-me and the numbers involved are small."

Membership of other types of voluntary association is, to the best of

my knowledge, unknown among African nurses. Insurance policies, for instance, fulfil some of the functions of the umgalelo clubs described by Wilson and Mafeje (1963:114), and socialising among the nurses, as part of the elite stratum, is effected on the basis of personal friendships. It does seem that interest in joining voluntary associations, is low among African nurses. Individualism and what might be termed the "cult of privacy" appear to dominate the attitudes and behaviour patterns of the nurse-elites, for reasons which will be discussed in the next chapter.

An Ideology of Corporateness: A Brief Note.

I have attempted to show the ways in which certain values and attitudes influence, if not determine, the limited interest in association membership displayed by African nurses. By definition, nurses form a fairly corporate professional grouping, which is reflected, to some extent, in the activities of nurses in the South African Nursing Association, and its local branches. But nurses do not, in general, form easily identifiable, corporate social groupings. Generally, nurses tend to exhibit disinterest in formal social organisations, and it is very difficult to demonstrate "corporateness" among African nurses in terms of their social behaviour -- except for their friendships with other nurses, and the existence of the Catholic Nurses' League. However, there is evidence to suggest that an ideology of corporateness exists among nurses, even if this is not always displayed in actual behaviour.

And perhaps an ideology of corporateness is, in itself, more significant than overt social alignment, particularly for an elite group, for, as Nadel (1956:416) points out:

> "...for the 'wealthy' to be an elite (rather than a mere class of people) it is not necessary that they should be organised in a Rich Men' Proteotion Society or a Millionaries' Club:

> but their actions and the exercise of their particular superiority must follow from the premise 'We, the wealthy...'"

Indeed, the beliefs, thoughts and perhaps even the actions of the African nurses I knew, could well be said to follow from the premise "We, the nurses..." or "I, as a nurse...". The close identification of nurses with other nurses results, at least in part, from their common socialisation into the nursing profession, and is seen in the various ways in which nurses differentiate themselves from the remainder of African soceity, as well as in their "positive identification" with other nurses in some formal associations. Yet even though nurses do differentiate themselves from the rest of the African population, elite and non-elite, they are linked to the non-elite community in a number of ways, which will be discussed in the next chapter.

CHAPTER FIVE

LINKAGES IN THE SYSTEM OF SOCIAL RELATIONSHIPS

While the differentiation of African elites from the general population is quite marked, the links between elites and non-elites are, perhaps, equally noticeable. Particularly in South Africa, there is little residential segregation of elites and non-elites, such as exists in most other African countries. Furthermore, nurses, in particular, spend their working lives in close physical contact with their predominantly non-elite patients, for they work with and among the masses. Finally, as has been reported from most other parts of Africa, the elites have consanguineal and affinal ties with those who are uneducated, and such kinship ties are not always easily broken. All such relationships with non-elites may be seen within the elites' own framework of responsibility to share their knowledge with those, whom they regard as less fortunate than themselves, who are not educated.

African nurses are well aware that they constitute part of the educated stratum of African society, and they regard it as their responsibility, as educated people, to dispel ignorance among their uneducated fellows, especially those to whom they are personally linked. The words of delegates to the 1970 Congress, speak for themselves.

> "...And our jobs, educating others, thinking of ourselves as the trained nurses of the community. We have to remind ourselves, we have to be reminded, that we have to try our best to attain the aim of educating our patients..."

> "...So I am confident that the nurses will help the community by educating them to know what is right and what is wrong..."

> "When you meet somebody in the street, that person does not need to be ill to be a patient. As we all know, in community health, prevention is better than cure, and even if that

> person is not requiring a cure, every human being is a patient as far as the nurse is concerned. You are there to give advice. You are there, not to criticise, but to tell them, in a very fine bedside manner, what ought to be done and what ought not to be done..."
>
> "The African is looking from traditional guidance and ways of living, to the modernised way of <u>health</u>."

In stressing that they are in a position to "educate" the uneducated, African nurses are, in effect, asserting their own imitability as far as knowledge and values are concerned. When examining African nurses' relationships with non-elites, one must bear in mind that an awareness of their own imitability (which Nadel (1956) does not mention), appears to be particularly important where elites are attempting to foster acceptance of a new cultural framework at the expense of the existing one. Thus elites use their personal relationships with non-elites, to promote acceptance of their own ideas and values. An examination of nurses' relationships with certain categories of non-elites, gives some idea of how elites may and do use such relationships to promote their own imitability.

<u>Non-Elites Outside the Kin Network: Patients, Neighbours and Domestic Servants.</u>

Because the nurse-patient relationship is structured and formalised, the "educative function", or imitability, of the nurse is rarely apparent in this relationship. However, as part of their authority role over patients, nurses are expected to teach patients whatever they should know concerning diet, hygiene, and so on, with specific reference to their particular diseases. Hence it is probable that the African nurses' self-confessed responsibility to "educate the people" stems from the expectations of the professional nurse role, at least in the initial instance. The nurses' imitability is, however, seen more clearly in their relationships with neighbours and domestic servants

than in the professional nurse-patient relationship.

In South Africa, the process of residential segregation of elites, in elite suburbs, has been less marked than in other African countries[1]. Elites in South Africa mostly reside among the rest of the population -- the wealthy among the poor, the educated among the illiterate, the respectable among the less respectable. While this situation appears to have fostered the emphasis on privacy found among South African elites, it has also resulted, in some cases, in elites deliberately "educating" their neighbours.

One particularly clear illustration of the educative function or imitability of African nurses, and how nurses themselves promote this imitability, occurred during the course of my fieldwork. In one of the newer sections of Umlazi township, land available for individual purchase and private building, is intermingled with plots on which township houses have been erected by the government housing authority. One of the private stands had been bought by my informant, a nursing sister at a provincial hospital, and her husband, a relatively high-ranking member of the South African Police, who was previously a teacher. They had built privately on this land. Immediately next door, in an ordinary four-roomed township house, lived an unskilled industrial labourer, his wife, and their family of six girls: a seventh child was expected shortly. In this house, the sparse furniture had been made by the man himself (he had once assisted a White carpenter). However, the house itself was spotlessly clean and tidy, as were the shabby clothes of the woman and her daughters. My informant showed me around this house with great pride, telling me of the frequent requests to her for advice and, occasionally, assistance with food and money. Finally, <u>en route</u> back to her own beautifully furnished, three-bedroomed house, she said:

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[1] To the best of my knowledge, Dube Village (Soweto) is the only truly elite African suburb in the whole of South Africa.

> "I am so proud of that woman! Even though they do not have money -- I would never manage on what she does -- still she has learned so well what I have tried to teach her about hygiene and cooking. It is a pity that they have so many children, but you know our Zulu custom that there must be a boy in the family...I hope the child she is expecting is a boy, or else the husband will insist on trying again! And you can see they are poor. Another child will be <u>too</u> much..."

However, while nurses may be approached by their neighbours for advice and assistance, there is usually little direct contact between nurses and their non-elite neighbours. As I have already mentioned, nurses tend to hold aloof from the activities of public associations and societies, and place great emphasis on their privacy. I would suggest that at least part of their reason for withdrawing from the public eye, lies precisely in the residential integration of elites and non-elites in South Africa, which might, perhaps, be expected to encourage social integration. For nurses, along with other educated Africans, are subject to certain community expectations regarding their behaviour. As Wilson and Mafeje (1963:79) note, for instance:

> "'If a staff nurse lived with a lover, openly, the whole of Langa would know about it immediately.'"

Where elites and non-elites are residentially integrated, the news of misbehaviour on the part of elites spreads rapidly, threatening to bring entire categories into disrepute, which in turn could lead to loss of prestige. Thus the elites stress the value of privacy and keep to themselves. It is my impression, from the literature dealing with elites in West Africa, and from my own research experiences in South Africa, that the social distance between elites and non-elites may be greater in South Africa than in West Africa, where residential segregation of elites and non-elites is well-defined. Thus, although the imitability of elites may be more readily apparent, more overt, in situations where they are living cheek-by-jowl with non-elites, this situation may also make the elites more aware of the

necessity to remove themselves, socially, from interaction with non-elite neighbours.

However, while interaction with neighbours may be cut to a minimum, there is one category of non-elites with whom nurses, in particular, interact extensively: their domestic servants. The servant virtually becomes part of the nurse's family. She lives with the family, shares their food, assumes many if not most of the mother's functions vis-à-vis the children. Indeed, the domestic servant usually calls her nurse-mistress "sis", a term which Vilakazi (1965:41) states has derived from the Afrikaans "sussie" (meaning "little sister"), and which definitely denotes a pseudo- or fictional kin link in this context[1]. This fictional kin link is one means of binding the servant more closely to the nurse, and stresses the obligation of the servant in this relationship. Such a link is necessary, for the problems involved in employing and retaining the services of a competent maid, are ones with which the African nurse, like the suburban European housewife in South Africa, is only too familiar. As one of my informants stated:

> "We take them into our homes, and treat them as one of the family. They eat the same food that we do, sleep on our beds, and still they abuse us. We teach them how to iron, and cook, and clean properly, and the next thing -- they are gone! Sometimes they even just walk out, and we do not know that they are gone until we come home and find a dirty house, and no food prepared, and the children tell us. They say that they want to go and work for the Europeans, but we treat them just as well as they do."[2]

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[1] It is interesting to note that the term "sis" (which is used only by the servant to the nurse, and not symmetrically), implies an "egalitarian" relationship, which does not exist. Perhaps this term "sis", in addition to stressing the obligations of the servant role (in the traditional idiom of kinship?), is a means of reducing tension in the nurse-servant relationship, in which the nurse wields recognised authority, by allowing the servant to verbalise, or to assert verbally, a status of equality with the nurse. Perhaps the nurse is prepared to permit such (verbal) equality, as long as she is in control of the elite-non-elite relationship, and her higher status is not disputed. Relations with aunties contain no such egalitarian implications.

[2] Preston-Whyte (1969:200) notes, from the servants' point of view, there is no prestige, in terms of contact with the dominant (European) culture, involved in working for Africans, elites or otherwise.

Two of the possible solutions to the problem of retaining the services of a maid, are to employ either a kinswoman (preferably in a known, rather than classificatory, relationship), or else a member of the same church congregation. Three of my regular informants had employed kinswomen, and two others has gained the services of fellow-worshippers. The rest of my informants were struggling to solve the problem, and expected to have a new maid every two months or so. When a kinswoman or fellow-churchgoer is employed, of course, certain sanctions operate to tie the servant in a fairly close relationship to the nurse (as a high-status member of a closed group to which they both belong), and to lay her open to correction from those with whom she interacts, should she not fulfil her duties adequately.

The nurse deliberately inculcates into her domestic servant, her own values and practices, ideas and behaviour. She teaches the servant to run a modern home, emphasising the importance of hygiene and child care, diet and budgeting. The knowledge she imparts is not solely concerned with ensuring her own material comforts, for the servant is expected to apply what she has learned from the nurse, to her own home when she marries. The benefits to the servant of such teaching, are regarded by the nurse as long-term: one of the ways in which she can and does "educate the people" is through the series of domestic servants she employs.

In this situation, where elites deliberately teach others to follow their example, thus promoting their own imitability, it is highly probable that one of the most important ways in which their ideas and values permeate the general community, is through those women who work for them. In other words, members of the elites' (in this particular case, nurses') <u>effective</u> social networks, may be as important as those on the periphery of their extended networks, in disseminating information on elite life style to the

masses. Epstein (1961) does not appear to have considered this possibility, for he states (1961:59):

> "I suggest that new norms and standards of behaviour will tend to arise more frequently within the effective network of those who rank high on the prestige continuum, and that through the extended network they gradually filter down and percolate through the society."

While I have no quarrel with this suggestion, my own research experience leads me to suggest that the norms and standards of behaviour acquired by African nurses' domestic servants (who must be rated as members of the nurses' effective networks, on the basis of the data given above), may be transmitted to members of the servants' own effective networks. It is possible that norms and values thus filter down from one effective network to the next, transmitted (in the initial instance, at least) by low-status members of the network. In this model, it becomes necessary to visualise one person moving between discrete effective social networks, thus establishing communication between networks of decreasing status order, in addition to visualising increasingly tenuous links connecting people in the extended network. Obviously, both of these models have explanatory value in the context of the dissemination of new norms and values through the society, for while servants are part of the nurses' effective networks, non-elite neighbours can only be regarded as part of the nurses' extended networks, in terms of actual interaction.

The social networks of African nurses' domestic servants constitute one channel of (largely one-way) communication between elites and non-elites, but the nurses' own kin networks are also important in this respect. Biologically close kin form an important part of the nurses' social networks, whether or not such kin may be regarded as elites. Thus domestic servants and uneducated kin may be regarded as points of articulation between elites and non-elites: they are factors common to the systems of social relationships of elites and

non-elites alike.

Patterns of Kinship: Consanguinity.

The data on which much of this section rests, are the genealogies[1] of nine of my regular informants. These nine cases are not necessarily representative of African nurses in general, and the very small number of cases does not warrant firm generalisation. However, the points that emerge from an examination of these genealogies, do appear to have wide applicability among African nurses.

The first point of interest pertains to the actual numbers of kinsfolk recalled by these elite nurses. Even though many kin links have been attenuated with the geographical dispersal of members of kin groups, African nurses recognise large numbers of kin, patrilateral and matrilateral. This recognition would appear to suggest that kin ties are not easily forgotten, even if they are not activated. Table 4 draws a distinction between the minimum numbers of kin these nurses recognise (that is, all those persons who appear on their genealogies), and the numbers of these recognised kin whom they can actually name. As may be seen from table 4, there is a tendency for the older nurses to come from the larger kin groupings. While this tendency is undoubtedly partly a function of the stage of the developmental cycle of each family group, it does seem possible that there may be a decrease in the sizes of sibling groups with the spread of literacy, since it is the younger nurses who have parents that are both literate. In other words, it may be that the younger nurses, from the background of parental literacy, come from families where the number of children has been restricted.

[1] Three of these genealogies are reproduced in chapter eight.

TABLE 4. Analysis of recognised and named kin (dead and alive) from the genealogies of nine selected African registered nurses.

Nurse's Age; Tribal Identity; Place of Origin.	Recognised Patrilateral	Named Patrilateral	Recognised Matrilateral	Named Matrilateral	Immediate Kin Group[1]	Total Number of Kin Recognised
23; Xhosa; Umtata	56	45	19	15	11	86
24; Zulu; Greytown/ Durban	35	28	30	30	7	72
26; Zulu; Thafamasi	69	59	28	26	8	105
28; Xhosa; Matatiele	38	23	37	23	6	81
29; Xhosa; Engcobo	44	31	48	32	15	107
32; Zulu; Ladysmith District	72	38	58	35	41	171
34; Zulu; Vryheid District	32	28	19	13	18	69
35; Zulu; Umzumbe	79	53	72	40	15	166
37; Zulu; Durban	134	79	15[2]	7	5	154

It should be noted, however, that even though these informants recognised such large numbers of kin, their interaction with kinsfolk was limited to maintaining contact with their parents (if still alive), their siblings and siblings' offspring, and occasionally one or two of their parents' siblings, with whom they had had particularly close ties. Even with these immediate kin, however, personal interaction is limited, particularly where such kin do not live within commuting distance of the nurses. As may be seen from table 4, seven of these nine informants came from places other than Durban, some from

[1] Ego's immediate kin group comprises ego's parents, siblings, siblings' children and ego's own children.

[2] This particular informant's mother died two weeks after my informant was born, and her father remarried the following year. Because she was raised by her paternal grandmother and, later, her step-mother, she has had virtually no contact with her matrilateral kin and hence knows very little about them.

places hundreds of miles distant. Personal contact in these cases is, therefore, maintained by visits home during annual leave, the occasional long-weekend visit, and through correspondence.

Although interaction with kin is restricted, however, there are certain obligations to kin which nurses do not evade. In the course of my research, I did not meet a single nurse who denied or evaded her financial responsibilities to close kin, particularly for educational purposes. As students, part of these nurses' pay went to their parents to help educate younger siblings. As trained nurses, they kept their school-going siblings in pocket-money and clothes; or afforded them accommodation without charge while studying; or paid school fees for a sibling's child. The nurse's obligations to her kin were regarded as quite distinct from those of her husband to his kin, and each spouse met his or her own financial obligations to kin. These obligations fit into the nurses' framework of responsibility, discussed previously, to "educate the people", especially those who are linked to them by ties of kinship.

The second type of financial obligation never shirked by the nurses I knew, was their obligation to elderly kin, particularly parents. Once their parents reached retiring age, the nurses (in conjunction with their siblings) contributed financially to their support, or else insisted that their parents live with them (in cases where the nurses' homes were large enough to make this possible). The obligation of caring for the parents who had educated them, like the obligation to educate close kin, is assumed without question.

A further examination of the genealogies reveals some interesting social characteristics of these nurses' lineal kinsfolk. If a definition of literacy as the successful completion of at least six years of schooling[1], is accepted,

[1] For ease of comparison with the situation in certain West African countries.

it may be seen from table 5, that literacy in the second ascending generation, is virtually unknown. Over half of these nurses, however, have parents (first ascending generation) who are both literate, in terms of the above definition.

TABLE 5. Literacy among parents and grandparents of nine African nurses.

Kin Category	Literate	Semi-Literate[1]	Illiterate	Total
Father	7	2	0	9
Father's father	1	0	8	9
Father's mother	0	0	9	9
Mother	5	2	2	9
Mother's father	0	1	8	9
Mother's mother	0	0	9	9

These data may be compared with those given by White (1966:16-17). Among the group of twenty-eight student nurses he studied, eighteen fathers and nineteen mothers were literate in the sense of the above definition. It would seem, then, that between half and two-thirds of African nurses come from a background of parental literacy, but (in terms of my own data) virtually none of them have grandparents who are (or were) literate. However, the religious affiliation of members of the grandparental generation, presents an interesting pattern, as may be seen in table 6.

TABLE 6. Religious status of parents and grandparents of nine selected African registered nurses.

Kin Category	Christian[2]	Pagan
Father	9	0
Father's father	7	2
Father's mother	9*	0
Mother	9	0
Mother's father	8*	1
Mother's mother	9*	0

[1] Defined as less than six years of schooling, but has attended school.

[2] * indicates one Zionist/Shembe adherent in each category: total 3.

It would appear that there may be some connection between the high rate of affiliation to Christian churches, found among the grandparental generation (shown in table 6 above), and the high literacy rate in the parental generation (shown in table 5 above), of these particular informants. I would speculate that those persons who were sufficiently receptive to missionary influence to affiliate themselves to Christian churches, were also responsive to missionary suggestions that they should have their children educated.

However, what does emerge quite clearly from these data, is that a certain proportion of these nurses' parents, and the large majority of their grandparents, must have been of similar outlook to the people now stereotyped by African nurses, as aunties, gogo's, uncles and baba's, discussed in the previous chapter. In other words, the majority of these nine nurses' lineal kinsfolk in the first and second ascending generations, are (or were) non-elites. Some of these nurses explicitly stated that certain problems in their relationships with older kin stemmed from such lack of education. One informant (aged thirty-six) stated the position in her own family thus:

> "I enjoy spending week-ends with my 'Mum' at home, but not too often. If I was living at home all the time -- boy! We would fight most of the time! She does not like the length I wear my skirts, for instance. And she thinks I am bringing her granddaughter up very badly. And I fight with her when she is sick to go to the doctor -- she says there is nothing wrong with her and she doesn't want to bother him...No, it is good that we live apart, for this way we both live in peace, and when we do see each other, we are so glad that we can forget the differences for a little while and enjoy the company."

If this is the position in the nurse's own family of orientation, precisely the same problems exist in her affinal relationships, where the structural tensions are more obvious, and are emphasised far more by the nurses themselves. I shall return to this point later.

Given the facts that African nurses continue to recognise ties of kinship, and that there are certain tensions in their relationships with uneducated kin, especially close kin, their recognition of the obligation to help educate kinsfolk, is both logical and understandable. It would seem, from my data, that elites are not always as quick to shed the obligations of kinship as has sometimes been suggested (for example, by Lukhero, 1966). Instead, African nurses in Durban, at least, attempt to draw their own and younger generations, into their own social stratum, through education. With reference to younger kin, they are promoting not so much their own imitability, as occupational ambitions and aspirations, through their example. The example they uphold in the educational field, is shown clearly in their ambitions for their own children, and their deliberate limitation of family size in order to achieve these ambitions.

A consideration of family structure among African nurses, affords an opportunity to contrast elitist values with traditionally-oriented interests. African nurses express preference for a small family of between two and four children. This preference is put into practice by the deliberate limitation of family size, through the use of modern contraceptive techniques, particularly "the pill". An extreme example of this desire for a small family may be seen in the case of one informant who, at the age of thirty-four (having married at thirty), underwent tubal ligation immediately following the birth of her second child, by Caesarian section. As far as I know, there was no medical reason to warrant this procedure: my informant merely stated -- emphatically -- that she couldn't face the thought of having any more children! Her action conflicts not only with traditional African values, but also with the teachings of the Catholic church, of which she is an active member.

Nurses give two major reasons for desiring small families: firstly, with

a large family, maintaining their high standard of living would be virtually impossible, particularly in view of their kinship obligations discussed above. Secondly, there is the consideration of the future costs of higher education for all the children they do have. Without exception, all the nurses I spoke to on this subject, expressed the hope that their children, boys and girls, would all attend university. Some of them, while their children were still in the lower standards of primary school, had started to save, specifically, towards education costs which will only materialise in ten or more years' time[1]. The nurses' attitude is epitomised in the words of two Congress delegates:

> "We are dying for education. We need our children, the coming generation, to be educated. We do not want to say that money is the thing we need, but education, and knowledge, and all these things revolve around one thing -- money."

> "We do feel that demands are imposed on our children of leadership, study and example."

Not only do nurses express a preference for relatively small families: as may be seen from table 7, the majority of nurses actually have small families. But it should be noted that modern, effective methods of contraception, notably oral contraceptives and intra-uterine devices, have been generally available only in the last ten to twelve years, and the use of these contraceptive techniques depends on the female rather than the male.

Bearing in mind that the majority of these questionnaire respondents are still of child-bearing age, it is obvious that the figures in table 7 cannot be regarded as final indices of family size. However, it may fairly be assumed that the families of nurses in the forty to fifty age category

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[1] African nurses are thus now in the process of contributing their offspring to the ranks of the future educated elite, duplicating the tendency noted in West and East Africa, for the educated stratum of one generation to provide a significant proportion of the elites in the following generation.

are complete, and it may be seen that the median for this category is three children, while the average is 3,5. It should be remembered that these nurses, during most of their reproductive lives, did not have the use of modern contraceptives in so limiting their families.

TABLE 7. Numbers of children born to 226 African registered nurses, according to age and marital status.

Age and Marital Status of Nurse[1]	Number of Children								
	0	1	2	3	4	5	6	7	8
Under 30: single	21	4	-	-	1	-	-	-	-
Under 30: married	5	13	9	5	3	-	-	-	-
30 - 40: single	15	8	-	1	-	-	-	-	-
30 - 40: married	6	8	22	22	14	11	1	-	-
40 - 50: single	5	1	-	-	-	-	-	-	-
40 - 50: married	2	4	6	11	10	3	5	1	1
Over 50: single	-	-	-	-	-	-	-	-	-
Over 50: married	2	-	1	1	1	3	-	-	-
Total: single	41	13	-	1	1	-	-	-	-
Total: married	15	25	38	39	28	17	6	1	1
GRAND TOTAL:	56	38	38	40	29	17	6	1	1

Furthermore, if the total number of children (486) born to nurses who responded to this questionnaire, is averaged among the total number of respondents (226), the resulting figure is 2,15. If the total number of children (486) is averaged among only those nurses, regardless of marital status, who have actually born children (170), this average is still only 3,01 children per mother. Thus a small family is not only the logical corollary of African nurses' values regarding both their standard of living and their

[1] In this context, "single" indicates never married, whereas "married" includes widows and divorcees, as well as persons whose marriages are continuing.

children's education, it is also an established social fact within this particular professional group.

The fact that the use of contraceptives to limit family size, conflicts with traditional African values, has been mentioned previously. Nurses' attitudes to children and family size thus conflict with those of non-elites, including their kin. These attitudes also conflict with those of their senior affines, and constitute an extremely important aspect of the tension in nurses' relations with their in-laws: this point will be taken up in a later chapter.

Differentiation and Linkage: A Concluding Note.

In chapter four, I tried to analyse some of the ways in which nurses distinguish themselves, and are distinguished, from different sections of both the elite stratum and the general African population. In this chapter, I hope I have shown how the nurses' personal relationships with certain non-elites, such as neighbours, domestic servants and kinsfolk, link them back to the community. In one sense, these linkages cross-cut the social characteristics by which nurses identify themselves as elites. For instance, nurses' kinship obligations are a financial liability, and detract from the attainment of the potential standard of living associated with their income level. Again, I have dealt with the paradox that, while nurses live among the community at large, they cut themselves off from social interaction within this community, and withdraw into an isolationist "cult of privacy". Yet at the same time, their sense of responsibility to those less educated than themselves (and possibly the desire to flaunt their greater knowledge), leads them to involve themselves with certain non-elite members of the community. It seems that African nurses accept the fact that they are linked to some non-elites, and

instead of trying to break these links, they attempt to alter the non-elites, to fit in with their own ideas and values.

However, there is one set of ties to non-elites which nurses do not accept passively. Among nurses, affinal ties have a tendency to become eroded. Nurses reject patrivirilocal marriage, the authority of the mother-in-law role, and many traditional obligations to affines. If a nurse's husband is called upon to assist his kin, for instance, the nurse does not regard it as her obligation: her husband must see to his own kin, from his own pocket. It would seem that affinal relations are the point at which the nurse cannot afford to acknowledge non-elite ties and make the best of them. If she does submit to the authority of non-elite affines, her elite status will be endangered, for she will be expected to comply with non-elite, even anti-elite, expectations. It is with reference to marriage and its problems, to which I shall now turn, that nurses assert their elite status with greatest vigour.

CHAPTER SIX

COURTSHIP AND MARRIAGE

Probably the majority of African nurses expect to marry at some stage of their lives, for, as Kuper (1965:230) indicates: "Marriage is considered the normal relationship of adults". The late average age at which nurses do marry (26,3 years among questionnaire respondents), is partly a result of their lengthy professional training, but it would seem that, in general, nurses are in no hurry to rush into marriage once their training is completed.

> "Yes, I have a boyfriend, but we are not thinking of getting married. I will think about getting married when I am twenty-seven, twenty-eight...in five years time, perhaps. I want to further my education and travel around first." (Informant aged twenty-three.)

> "My boyfriend wants me to marry him, but I don't know... I am not ready to get married yet. I have applied to do Psychiatric Nursing. And I would love to go overseas." (Informant aged twenty-four.)

While the state of marriage is approved, however, African nurses are singularly aware of the problems that marriage may entail. A minority of nurses remain single, rather than marrying for the sake of the increased status, or prestige, that marriage itself may confer, regardless of the circumstances of the man involved.

> "Look, I would very much like to get married, but I have not met a suitable somebody yet." (Informant aged thirty.)

> "No, I am not married. Mr. Right has not turned up yet. I am still waiting for him!" (Informant aged thirty-three.)

The incidence of marriage among nurses belonging to different age

categories, may be seen in table 8.

TABLE 8. Marital status of African registered nurses according to age.

Marital Status	Under 30	30 - 40	40 - 50	Over 50	TOTAL
single	26	24	6	0	56
married	34	72	31	6*[1]	143
separated	0	2	1	1	4
divorced	0	5	6	1	12
widowed	1	5	5	0	11
Age category total:	61	108	49	8	226
Age category %age:	26,8%	47,8%	21,9%	3,5%	100%

Table 8 shows that, of the nurses who responded to the questionnaire, 42,6% of those under the age of thirty years, were single. In fact, I have reason to believe that this relatively low percentage reflects a bias in the response to this questionnaire, since many young and single nurses commented that it was "only about marriage. It doesn't concern me for I am not married". Although I explained that this was not the case, I am not sure that this explanation was always accepted. My own impression is that a majority proportion of nurses under the age of thirty, are single, even though the questionnaire response shows the reverse situation. Hence the total percentage of nurses who have never married, is probably higher than the figure of 24,8% shown in table 8. However, if one includes nurses who are separated, divorced or widowed, along with those who have never married, in the category of effectively single persons, 36,7% of nurses who responded to the questionnaire, fell into this category. Thus nearly two-fifths of these respondents were, for most practical purposes, independent of male control, and at least some of the practical problems encountered by married nurses in their everyday lives, were inapplicable to those nurses falling into the "effectively single" category.

[1] * One respondent in this category had previously been both widowed and divorced, neither of which are reflected in table 8.

Single Nurses and their "Boyfriends".

The interests and activities of married and unmarried nurses obviously differ considerably, in response to their differing duties and obligations. The married nurse has a family and home to absorb most of her free time, whereas the unmarried nurse may or may not be involved in normal family life. If she is living in the same town as her parents, the qualified, single nurse may be an important part of her family of orientation, in everyday life. But she is more likely to be working away from home, living in a nurses' residence, renting a room where she can, or staying with other unmarried nurses in a township house set aside for the use of unmarried nursing staff working at a particular hospital. Wherever she is living, however, she does not have the responsibilities of the roles of wife and mother (except in isolated cases of illegitimacy).

The single nurse is thus free to do what she likes when she is off duty, and there are no restrictions on the amount of time she can spend on social activities. She is also relatively free of financial obligations, for, although all the unmarried nurses I knew were assisting with the education of their younger siblings, such financial contributions never exceeded one-quarter of each monthly salary cheque. The single nurse, on average, probably spends much more on her own personal clothing, cosmetics and entertainment than her married colleague, on average, can afford. It is probably no exaggeration to say that, on marriage, the nurse exchanges her dress shop accounts for hire purchase agreements involving furniture. Expenditure patterns, of course, reflect both interests and obligations: among single nurses, their budgeting primarily reflects their own interests, whereas among their married colleagues, the obligations of their married roles predominate.

Most young, unmarried nurses go out, usually with their boyfriends[1], once or twice a week, to evening entertainments such as the cinema, live shows, dances or dancing classes, parties, and so on. Picnics and trips to the beach are acceptable daytime entertainment.

Initial meetings with men who are later categorised as boyfriends, occur in a variety of ways, ranging from chance encounters on shopping expeditions, to formal introductions from friends or, less frequently, kin. The initiative rests with the man to follow up the initial introduction. If his attentions are unwanted, however, the nurse has -- and has no compunction about using -- a foolproof system of excuses, based on her irregular duty hours, which enables her to avoid unwanted telephone calls and visitors.

Once established, however, the steady relationship between a nurse and her boyfriend can be maintained, if necessary, at a distance, through correspondence. I was told that many student nurses have boyfriends in their home towns, and many registered nurses have boyfriends in the towns where they trained, and whence they have since moved. Although the boyfriend status derives from a semi-permanent relationship which can be continued despite geographical separation, and although this relationship may lead to later marriage, the nurse will have little hesitation in breaking off the relationship should her boyfriend's behaviour displease her. One of my informants, for instance, had a boyfriend in his fifth year of medical studies. She had known him for over two years, but he had been regarded as her boyfriend for less than twelve months, and she was already considering breaking off the relationship, regardless of his status as an aspirant doctor.

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[1] The term boyfriend is usually (though not necessarily) indicative of a sexual relationship existing on a semi-permanent basis. In view of this and other connotations of the term when it is used by Africans -- which connotations are not necessarily implied in the same term when used by Europeans -- I have used boyfriend as a "vernacular" term throughout this section, hence it is underlined. (Cf. auntie, in chapter four of this thesis.)

> "He proposed love-making to one of the midwives here at McCords, who is a friend of mine. She told him that he should be ashamed of himself, for he knew that I was her friend. She told me what had happened and I was very angry. I am still angry, because it shows that he does not respect me. If he had asked somebody else, at Kings, I would not mind so much -- somebody that I don't know. But not my own friend. We all know that men are weak, but this is very bad. How can I continue with a man who does not respect me?"

(The situation referred to had arisen only a few days previously, and my informant was obviously extremely upset about it. When I met the midwife friend -- who was the sister of one of my other informants, at a different hospital -- some months later, she also mentioned this event, and agreed entirely with her friend's action in terminating the relationship.)

Should the nurse terminate the relationship with a boyfriend, however, she has to consider the possibility of retaliatory action, which may take the form of physical assault[1], or else a more subtle plot to disturb any new attachments she may form, either by magical means, or by making her appear "cheap" in the eyes of her new boyfriend. To what extent magical means actually are used to retain or regain the favours of a nurse, I do not know, but these means are sometimes threatened. Such threats, a few of which were discussed quite spontaneously with me, were treated as a joke, or with contempt, by my informants, for African nurses overtly classify such beliefs and practices as uncivilised and superstitious. I was quite unable to find first-hand evidence of the assertion that some nurses themselves use magical practices in their love affairs. Nurses themselves say that they have better things to spend their money on, and that their salaries do not run to useless expenditure on muti. I am inclined to think that, with possible individual

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[1] In February this year (1971), a staff nurse was murdered while on duty in the casualty theatre of King Edward VIII Hospital, by a man whom she had recently refused to continue meeting as her boyfriend. The man, a well-known soccer player, was sentenced to twelve years' imprisonment. This case attracted widespread publicity in both African and European press releases. It was, of course, an extreme case of the point in question, and less extreme cases occur more frequently. (See Weekend World, Sunday 28 March 1971.)

exceptions, this is a reflection of their true feelings on the subject and that, in general, assertions that nurses do visit inyanga's and use magical herbs and potions, are possibly a reflection of envy and an attempt to discredit the image of the nurse.

Where the boyfriend relationship does involve sexual relations, as it very frequently does, the nurse is in a position that few African women are, for she not only knows which modern contraceptive techniques are most efficient, but also has relatively easy access to the method of her choice[1]. In large provincial hospitals, it seems that supplies of oral contraceptives are made available to the nursing staff, albeit by devious routes. It is also possible to have an intra-uterine device (I.U.D.) inserted. In smaller mission hospitals, where greater emphasis is laid on Christian morality, private practitioners outside the hospital may be willing to prescribe the "pill" or insert a loop or administer an injection of depo-progestogens, the dosage being absorbed slowly over a period of months. Whatever the method used, however, the important point is that a nurse will not expose herself, in normal circumstances, to the risk of an unwanted, illegitimate pregnancy, and she takes active precautionary steps against this possibility, rather than relying on her boyfriend's discretion. Bearing an illegitimate child carries the stigma of disgrace for an African nurse, both on account of her Christian upbringing, and her elite status. Illegitimate pregnancy during the training years may cost a student nurse her career, and such an occurrence is as much a disgrace to her parents as to the nurse herself.

> "Well, I know that some nurses try and trap a man into marrying them by falling pregnant -- especially the medical

[1] The use of contraceptives, and the desire for a small family (see chapter five, pages 103-106) are, perhaps, indications of a more "modern" attitude on the part of African nurses in South Africa, than that found among educated women in West African countries. Caldwell (1965) and Little (1966), for instance, report minimal inclination towards the deliberate limitation of family size through the use of modern contraceptives, among potential elites (students) in Ghana and Sierra Leone respectively.

> students. But I think that is stupid, because it never works. Either he will refuse to marry you, and there you are, left with the children, being a burden and a disgrace to your parents. Or else he will marry you because he has to[1], and play around with other women, and not come home, and it will end up in a divorce. Well, I don't know what the other nurses think, but I do know that Tandi (her room-mate) agrees with me on this point: neither of us would like to have an illegitimate child."

It would appear, however, from the questionnaire returns, that a significant proportion of unmarried nurses do have illegitimate children, since fifteen, of a total of fifty-six single nurses, were mothers. It is not unlikely that the majority of these illegitimate children were born during the nurses' student years, since it is possible, in some hospitals, to recommence training after bearing an illegitimate child, and thus to qualify. I have personal knowledge of only one case in which an unmarried nurse had a child after she had qualified. This nurse (a Catholic) has three illegitimate children and, in this respect and many others, is exceptional among African nurses.

Despite a fairly high proportion of unmarried mothers among single nurses, however, the overall legitimacy rate[2] calculated from the questionnaire returns, was extremely low, being a mere 4,1%. This figure would appear to indicate that, although a fairly high number of nurses do have illegitimate children, very few indeed have more than one illegitimate child. Bearing illegitimate children is not in keeping with the nurse's social position, for she is not only educated, and a Christian, she is also a "professional

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[1] Until fairly recently, a medical student at the University of Natal had to marry a girl he had impregnated, or else leave the Medical School.

[2] Calculated as $\frac{\text{number of illegitimate children}}{\text{total number of children}} \times 100 : \frac{20}{486} \times 100 = 4,1\%$

It should be noted that this is a minimum figure, since the questionnaire could not show up illegitimate children born before marriage, where the respondent was married. I know that some nurses, now married, have born illegitimate children, but this fact is not reflected in the figure of 4,1% given above. However, were such children to be included, I doubt very much that the total would rise above 8%.

somebody", a member of the modern elite, for whom such behaviour is undesirable and disapproved, and leads to loss of status or prestige. The elites are expected to bear their children within the framework of marriage.

Expectations of Marriage.

> "We nurses, or rather, we girls, have the bad habit of marrying men, or going out with them, because of their money, or their social position. But then, they also do this. A nurse is a 'good catch'!"

The nurse expects her boyfriend to dress well, to take her to places she wishes to visit, and to behave in a "civilised way". In addition to these expectations, however, the criteria of romantic love and respectability guide her choice of a husband.

The concept of romantic love is not easy to define, but as the African nurse sees it, love involves a man in primary responsibility to his wife, the woman he loves. He must, therefore, be prepared to put his wife's wishes before those of his parents and other kin, even where she will require him to break with tradition and custom, and even to go directly against the wishes and expectations of his kin. Love binds two individuals, a man and his wife, in a relationship from which others are barred:

> "I am hoping that all of the lobola business will be finished before the wedding day, otherwise there will be trouble. Always there is trouble with the lobola, and I don't want anything to spoil the wedding. After all, it is our day, his and mine, not theirs."

Any man who does not measure up to the nurse's expectations of the elusive notion of romantic love, is not regarded as marriageable.

> "B____ waited for eight years for me to change my mind and

> marry him. He is a very wealthy businessman. He is also a divorcé and so, because of my religion, I couldn't marry him anyway. But I never loved him. It is funny. He is a good man, a very fine person, but for me he is just a good friend. I could never have married a man I did not love... And as for E____ (her husband) nobody in my family understands why I married <u>him</u>! He is dark. He doesn't have money. <u>But</u> he is the one in whom there are the most qualities <u>I</u> wanted -- and I cannot tell you what precisely those qualities are, so do not ask me about that!"

While love is not easily analysed, however, the components of respectability are more readily identified. Firstly, the respectable man does not drink immoderately. Indeed, since the nurse is only too familiar with the problems attendant upon the excessive consumption of alcohol, the man she marries would ideally not drink at all. Most important of all, money must not be spent on drink at the expense of a high standard of living. Then too, education is an index of respectability, as is work stability, good taste in dress, modern recreational interests, and so on. A respectable person also claims affiliation to one of the orthodox Christian churches, whether or not he attends church regularly.

According to my informants, it would seem that many men "play up" to these expectations while courting a nurse, only to drop the pretence once the wedding has taken place. Because of her high salary and regular income, relative to most of the African population, a nurse is a decided asset, as a wife, to the man who is involved in a highly competitive labour market situation, as the non-professional African man is.

Bearing the above expectations in mind, it behoves a nurse to choose her husband carefully. There is, however, a dearth of suitably qualified African men from whom the nurse can choose. As I have shown previously, in chapter three, registered nurses alone probably outnumber the entire male professional and semi-professional elite, and many nurses, if they wish to

marry at all, must, therefore, marry non-elite men. I shall discuss in some detail the educational qualifications and occupations of nurses' husbands, in the next chapter, but it is necessary to mention here that, in terms of school education alone, 75% of African nurses' husbands have had the same or more schooling than their wives. Thus it becomes apparent that the quantity of education each category (nurses, and their husbands) has, is less significant than the quality of such education. The nursing training, for instance, is not merely a specialised technical training which instils knowledge and skills specific to the occupation of nursing, into those who undergo this training. It is also a very important socialisation process, initiating African students, in particular, into an ethos and a way of life that has arisen in and is peculiar to, industrialised and technologically developed societies. Because very few African men undergo a similar socialisation process, they do not share the same values and beliefs to the same extent as do the nurses, and they are thus regarded as being "less educated".

Despite African nurses' awareness of the difficulties entailed in marriage, however, the majority of them are, or have been married. This may be, as one informant told me, because at a certain stage in their lives, "they feel the need to marry". In view of the sexual referent in the boyfriend relationship, this "need" is unlikely to be sexual, but whether it is the result of cultural expectations, status expectations, or simply a desire to have (legitimate) children, is impossible to tell. Probably all three of these factors are involved.

Marriage Negotiations.

In Africa, it is a truism that marriage not only involves two

individuals, but also the kin groups of these individuals. As far as African nurses are concerned, however, this commonplace has important implications for highlighting their elite status. In the processes involved in contracting a marriage, the expectations and influence of non-elites on their elite kin, may be seen very clearly, for marriage is the field in which elements of African tradition and custom impinge most noticeably on the lives of African nurses. Yet, in this situation, the nurses' elite status is demonstrated more clearly, probably, than in any other aspect of their lives.

Once a nurse has accepted a proposal of marriage, usually from a boyfriend, negotiations are set in motion. The nurse will inform her mother that she is expecting visitors on a particular day, and her mother will relay this news of an impending suitor to the nurse's father, or guardian. Although, ideally, the girl should be at home when her suitor and his companions arrive, very often the nurse travels home with them, because of her restricted off-duty hours. She must be there, however, even though she is barred from the negotiations until agreement has been reached, and she is required to state her willingness to marry this particular man. Although the suitor takes with him the umkhongi, or traditional "go-between", and although he usually leaves the negotiations in the hands of this man (who may be a kinsman, or an unrelated friend), the girl's father or guardian is more interested in seeing the suitor himself, and assessing this man's suitability to marry his highly-educated daughter or ward. In provinces other than Natal, the father's or guardian's consent to the marriage is largely a formality, because if the nurse really wishes to marry her suitor, she can do so without even consulting her kin, as a small minority of nurses have done. In the other provinces, African women may marry by civil rites. However, for a marriage to be recognised under the Common Law in Natal, it must be performed by a priest who is a recognised marriage officer. Hence, in Natal, where the bride

requires her father or guardian to "give her away" in a religious ceremony, the agreement outlined above is necessary.

Once the lobola negotiations have been concluded, the nurse's family, including herself, and the negotiating party, usually sit down to a meal together. Although a goat or other animal may be slaughtered for this meal, this appears to happen only in roughly fifty percent of cases, although I do not have evidence from sufficient cases to quote this as an entirely reliable figure. Whether or not a beast is slaughtered seems to depend on the financial standing of the nurse's kin, and possibly on her guardian's age and educational background as well.

Lobola[1].

Attitudes towards the payment of lobola vary among African nurses. Some (mostly over thirty years of age) wholeheartedly support the principle that a man should express his love for his wife-to-be in tangible form, that he should "pay" for the privilege of acquiring a wife. Others are of the opinion that it should be the woman's decision whether lobola should be paid for her or not, and to whom it should go. (This attitude is an interesting assertion of status, and obviously conflicts with traditional ideas regarding the proper role of women in society!) Still others, mainly in the younger generation of unmarried nurses, feel very strongly that the custom should be abolished completely, because of its crippling financial effects on the newly-married couple. Money should not be spent on lobola payments at the expense of the anticipated high standard of living, according to these nurses, because such high lobola lands the married couple in debt for furniture and other necessities of life, and this, in turn, causes other problems. A high lobola payment may thus be regarded as one of the reasons why nurses do not

[1] Cf. Brandel, 1958, passim.

get married early; and because of the financial aspect, a high lobola payment may also be regarded as one of the reasons why marriages stand a good chance of failing, by African nurses who disapprove of the lobola custom. The difference between this attitude towards lobola, and that of the "average African", needs no emphasis, but is indicative of the cleavage in attitudes and values between elites and non-elites[1].

One aspect of lobola to which all African nurses object, however, regardless of their other opinions about it, is the tendency for "uneducated" husbands to remind their wives that they were "bought"[2]. Such a claim tends to occur in the heat of domestic quarrels, and all nurses resent such an attempt to assert authority and demand obedience.

Weighing against these negative considerations, however, is the "fact" (as nurses see it) that the payment of lobola solemnises a marriage in the eyes of African men, "even educated African men". Nurses are explicit about the polygynous nature, as they see it, of African men, and they are well aware that a man will have little compunction about deserting a wife for whom he did not pay lobola. This belief that lobola has a stabilising effect on marriage, would appear to be supported by questionnaire data, for of the fifteen nurses for whom lobola was not paid, five are either separated or divorced. Using the phi co-efficient, a correlation of -0,2429 reflects a low, but significant, negative correlation between the payment of lobola and the dissolution of marriage.

In any case, it would appear that the nurses' attitudes are really of little relevance, as yet, in determining whether lobola is actually paid, or

[1] Even though a similar range of opinion regarding lobola might be found among women in the general (African) population, I think that the proportion of nurses holding negative opinions is probably considerably larger than would be found among other sections of the population.

[2] This English term is used by nurses themselves, and is not a translation of a vernacular usage.

not. Table 9 shows that lobola was paid in the vast majority of marriages, according to questionnaire returns.

TABLE 9. Lobola payments according to age category for African nurses.

Lobola Amount	Under 30	30 - 40	40 - 50	Over 50	Total
not given	1	6	3	5	15
unknown	2	2	-	-	4
< 11 cattle	1	4	-	-	5
11 cattle	3	9	4	-	16
> 11 cattle	1	3	4	-	8
< R100	1	1	3	-	5
R100 - R199	3	12	11	-	26
R200 - R299	4	30	16	2	52
R300 - R399	7	9	-	-	16
R400 +	13	9	2	1	25
TOTAL:	36	85	43	8	172[1]
Total number of marriages continuing:	34	72	31	6	143

From table 9, it may be seen that there is a definite trend towards high cash lobola payments for nurses in the under thirty age category, and this trend is possibly the source from which disapproval of lobola, on financial grounds, derives. At the same time, however, table 9 also indicates that lobola has been given, almost without exception, in the youngest age category, whereas in the oldest age group, lobola was not given in 62,5% of cases -- possibly because of missionary disapproval. The trend towards high cash payments may be an indication of the necessity for a high lobola payment today, if only to cover the expenses involved in the elite weddings demanded by African nurses. The total cost of the wedding may be as high as R1000, and few cost less than R250. The modern trend towards high lobola payments may also reflect the status differential between nurses and a high proportion of their non-elite husbands: these payments may, perhaps,

[1] One respondent had contracted a total of three marriages.

represent "status purchase" on the part of non-elite men, though I do not wish to over-emphasize this possibility.

Lobola payments must be completed before the date of the wedding is finalised. The final completion of payment usually takes the suitor between three and six months, and the period between reaching agreement regarding the amount of lobola (when half of the amount is handed over, usually) and the final completion of payment, marks the official engagement. According to Brandel (1958) and Kuper (1965), the nurse herself may assist her fiancé with the payment of the lobola, but I did not find any instances of such assistance among my own informants, although some of them believed that it did happen occasionally. Although the wedding is deferred until payments have been completed, however, the engagement is made known as soon as the negotiations have been concluded satisfactorily.

The Engagement Party.

On the day following the lobola negotiations, the nurse and her fiancé, along with kin and friends, usually have their engagement ring blessed at a special church ceremony, by a priest. An address on the subject of betrothal is given during this service. Afterwards, a party is held, usually in the local school hall, for friends and kin. Soft drinks and light refreshments are served to the guests, followed by speeches and (ballroom) dancing.

The innovative and standard-setting functions of elites are seen very clearly in the institution of the engagement party, with its cakes and sandwiches, formal speeches and modern ballroom dancing, which follow on the formal blessing of the engagement ring. Thus, one of my informants[1], whose

[1] See chapter eight, "Mary-Jane".

natal home was on a farm in the Ladysmith district, was the first person in her family to have had such an engagement party: she is the seventh child. Her engagement party was the first in the district, and she is very proud of this fact, since the many people who attended it regarded her as being very modern and progressive. She herself feels that her prestige, both personally, and as a nurse, was enhanced by this event, which she had learned about during her nursing training at the McCord Zulu Hospital. That was in 1961. Today, ten years later, such engagement parties are quite common, even among non-professionals, and the example of the nurses, in earlier years, may be presumed to have been partly responsible for the wider diffusion of this practice.

The Kitchen Party.

While engagement parties are fairly common today, the kitchen party is not. The institution of the kitchen party appears to have originated, among African nurses, at the McCord Zulu Hospital, for awareness of this practice, among older nurses, appears to be restricted to those nurses who trained at McCord's. Most of the younger generation of nurses know about the kitchen party, but as far as I am aware, it is unknown among other sections of the African population.

The kitchen party is dependent upon the engaged nurse issuing a general wedding invitation to the entire nursing and medical staff of the hospital at which she works. If she issues such an invitation, a party will be arranged for her, either by her student group (if she is still a student), or else by her close friends, if she is trained. Although her close friends usually are her bridesmaids, the organisation of the kitchen party is not regarded as the responsibility solely of the bridesmaids.

Invitations to the kitchen party are issued, and a list of gifts for the kitchen is compiled. Each invited guest undertakes to provide one (or more) of the listed items, thus duplication of gifts is avoided. The proceedings are (supposed to be) kept secret from the central figure. Each guest brings, in addition to her gift, a plate of food, and the organisers provide tea. The party is usually held in the nurses' home, but always somewhere within the hospital precincts. The bride-to-be is taken by surprise (or is supposed to be), and there is much teasing and laughter as she unwraps all the gifts. When she is finished, tea and cakes are served. Later, she will write individual notes of thanks to those who presented her with gifts.

Should the bride-to-be omit to issue a general invitation to her wedding, however, her nursing colleagues feel themselves under no obligation to supply her with kitchen-ware. All attempts to organise a kitchen party after a small, private wedding, are doomed to failure. The element of reciprocity in this situation is marked. But contributing a gift at a kitchen party does not mean that the invitee is absolved from presenting a wedding gift.

The kitchen party is arranged on the basis of friendly relationships in the working situation, and involves hospital friends and colleagues, rather than non-nursing kin. As yet the custom appears to be restricted to African nurses, and is a further indication of their innovative role in African society.

Wedding Celebrations: Legal, Religious and Traditional Aspects.

The legal, religious and traditional aspects of marriage are clearly distinguishable in the weddings of African nurses, being separated from one

another by both time and distance.

If the marriage is to be valid and recognised under Roman-Dutch (Common) Law, an African woman and her prospective husband, in Natal, must register their intent to marry, in advance of the actual wedding, with the marriage registering authority in the woman's magisterial district[1]. Such registration involves the decision to marry in or out of community of property, and it would seem that the majority of African nurses marry out of community of property[2], which means that they are not subject to the authority of the husband's kin in the event of his death.

This registration requirement in Natal, which must be fulfilled before the marriage can be solemnised in a church ceremony, involves both parties to the marriage in a certain amount of inconvenience, since both must be present for the registration, and the registering offices are open only during normal office hours. It happens, on occasion, that the church ceremony has to be postponed because of difficulties involved in registering the marriage. This is, of course, most inconvenient when the printed wedding invitations (in English) have already been distributed, and all the other wedding arrangements concluded. Thus it usually happens that the wedding arrangements are not finally settled until the marriage has been registered, and this conveys the impression that the wedding has been organised very hastily indeed, though in fact, the plans will have been made months before.

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[1] A detailed account of the legal requirements for Africans contracting monogamous, common-law marriages in the four different provinces of South Africa, has been given by H. J. Simons, in his work concerning African women, but since he is a banned person, I cannot utilise his material.
Seedat (1969:99) deals specifically with this legal requirement of registration in Natal.

[2] See Seedat (1969:108 ff.) for a discussion of the implications of marriage in and out of community of property, as far as Africans are concerned.

After the registration, the couple are legally free to marry in church, and the vast majority of African nurses have large "white weddings", with as many as eight bridesmaids, plus groomsmen, flower girls and page boys, with the groom and his attendants in top hats and tails -- although at smaller weddings the male contingent may sometimes wear suits. This is the "society wedding" *par excellence*, and such weddings often receive detailed press coverage.

The church ceremony is followed by the European type of reception, at which tea and drinks, cakes and sandwiches are served to the guests; formal speeches are followed by the cutting of the multi-tiered wedding cake; and the bridal waltz precedes general dancing. This reception caters for the educated friends of the bridal couple, and European guests. Even though less educated kinsfolk may attend, the tone of the church ceremony and reception is very strictly western. As mentioned previously, the total cost of such celebrations varies between R250 and R1000, some of which is covered by the *lobola*, some by the nurse herself from her savings, and certain items (for example, photographs[1]) are the financial responsibility of the groom, particularly if *lobola* has not been paid.

Despite the importance of the "white wedding" or "church wedding" to the nurse herself (as evidenced by the effort and expense which go into organising it), there are few African weddings, even of nurses, that do not cater for the traditionally-oriented interests of the older generation of kin. The traditional celebratory slaughter of an ox at the groom's home may be delayed for as much as four years after the wedding has been solemnised in church, but it will usually be held eventually. However, traditional or

[1] Wedding albums are among the nurses' most prized possessions, and not being able to afford a photographer to cover the wedding is regarded as a social disgrace. Since I was unable to attend either of the two weddings that occurred among my informants during the course of my fieldwork -- since I did not have the necessary rural permits -- these albums were invaluable sources of information.

PLATE VI.

(a) Durban, 1961: at the Botanic Gardens, a young staff nurse assumes a typical pose for the wedding photographer.

(b) Mother and child: a staff nurse and her first-born son, aged six months.

customary celebrations at the bride's natal home[1] would appear to be more important (judging from informants' accounts) than those held at the groom's home. At the bride's home, the most important feature is the parade around the homestead by the bride and her attendants, dressed in their wedding finery. After this parade, the older women lecture the bride on her future duties and responsibilities as wife, daughter-in-law and mother. And as one informant said ruefully, "And how they lecture! Oh my!" Then the singing and dancing commences, along traditional lines, and the bride is required to show willing, by at least a few shuffling steps, to participate in this dancing. Formerly she would have danced solo, in her bridal beadwork: today the nurse uses her long white wedding gown as an excuse to retire early from this dancing, and not to do the traditional steps.

Feasting is the inevitable accompaniment of singing and dancing. At least one ox, usually two or three, plus a couple of sheep and numerous chickens, will have been slaughtered the previous evening, and the meat cooked by the bride's mother and other female kin. Served with stiff mealie porridge, rice and green relishes, the meat is washed down with brewed beer and soft drinks bought in town. Not only kin attend these traditional celebrations. Anyone is welcome to attend, and they come from far and wide, bringing food and gifts, usually small sums of money, for the bride.

When the feasting and dancing is nearly over, the bride and groom change into their "going away" clothes. The bride usually chooses a smartly-cut suit, with hat and gloves, expensive handbag and matching shoes, while the groom dresses in a conservative suit. Before the celebrations finally come to an end, they retire.

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[1] It is worthy of note that this type of customary celebration at the bride's home, may take place immediately before or (more usually) immediately after, the church wedding and formal reception.

While this type of traditional celebration is always held at the bride's home, close in time to the church wedding, the celebrations at the groom's home may be delayed; or cut down merely to a celebratory communal meal involving the bridal couple and the groom's parents; or even omitted completely. It would seem that the traditional celebrations at the groom's home fall into the "necessary evil" category as far as the nurse herself is concerned, and this is probably because of her outright rejection of patrivirilocal marriage and the authority of her mother-in-law. The majority of African nurses are not prepared to assume the role of umakoti.

> "I will not live with my husband's people. I don't care that it is the custom. I don't believe that it is good to live with your in-laws, and I won't. And if it causes trouble -- well, that is just too bad!"

> "No. It is never good. I would never live with my husband's parents. For some reason they don't seem to like us, especially if we don't settle down to live with them and listen to them in everything...Look at my in-laws. They think that there is something wrong with me because we have been married two years now, and have no children. They do not understand at all about family planning, so I cannot begin to explain to them."

And the obverse of this attitude is displayed by one informant, aged forty-one, who applauded her mother-in-law's refusal to stay with her only son and his family, because she felt such an arrangement would impose unnecessary strains on their family relationships:

> "She is very civilised -- the best mother-in-law in the whole world! No, I mean it -- the very best!"

The conflict situation involving a quite highly educated professional nurse and an uneducated elderly woman, in the roles of daughter-in-law and mother-in-law respectively, should not be minimised, especially in view of the traditional Nguni expectations of the umakoti. African nurses are not

prepared to submit themselves to the authority of older women whose knowledge is less than their own, whose ideas and beliefs are traditionally-oriented, particularly regarding matters of hygiene, diet and illness, and whose style of living differs radically from their own: hence their vehement rejection of patrivirilocal marriage. They do not expect to alter the ways of the older generation, but they do demand that their own lives be lived independently.

And insofar as the nurses succeed in their stand against the ideas of the older generation, and are able to reject patrivirilocal marriage, to establish (or persuade their husbands to establish) nuclear households, to limit the number of children they have and bring them up in accordance with their own ideas -- inasmuch as they achieve autonomy from the older generation, they do divide the African community, and set new precedents and different standards, which conflict with the old ones.

Thus it may be seen that, in their attitudes to and expectations of marriage, as well as in the actual details of wedding ceremonies, nurses do belong to the modern elite stratum of African society. And for the very reason that their conflicts with their non-elite kin are emphasised within the whole structure of marriage and its ensuing expectations and obligations, the elite status of the nurses is most apparent in this field. Nevertheless, while the nurses would appear to have won their battle against non-elite ideas regarding marriage, the new marriage situation that they have been responsible for creating for themselves, is not without certain significant problems, which, while these are not confined to nurses' marriages, are the result of their elite expectations.

CHAPTER SEVEN

MARITAL PROBLEMS AND THE DISSOLUTION OF MARRIAGE

As a "professional somebody", the nurse expects to continue practising her profession after marriage. It may indeed be a "privilege to be employed"[1] for a nurse, especially in a community where unemployment is rife, but it is also a right that has been earned by the successful completion of a long period of training for a particular occupation. Not only is the nurse's contribution to family finances a significant reason why she should continue to work after marriage, but her interests lie in the stimulating working environment, rather than in the mundane affairs of the home. One of my informants, for instance, cut short her six months' maternity leave, because she found domestic matters and her first-born "screaming brat" far less interesting than her job. Obviously, then, the married nurse faces the problems associated with being a working wife and mother.

Domestic Life and Conjugal Roles.

Once married, the nurse's domestic roles of wife, housekeeper and mother, are complicated by her hours of work as well as her absence from home. The African registered nurse works a five-and-one-half-day week, with split day shifts. Starting work at either 7.00 or 7.30 am, the earliest she will finish will be 1.30 or 2.00 pm, on her half-day off. If she is working a straight eight-hour shift, she will be free at 4.00 pm, but if she has three or four hours off during the day, she will be on duty until 7.00 or 7.30 pm. The very latest she can arise in the morning is 6.00 am, and if she lives far from her place of work, she may have to rise as early as 4.00 am.

[1] This phrase was used by a delegate to the 1970 Congress.

If she works until after 7.00 pm, she can expect to arrive home sometime between 8.00 and 9.30 pm. Many African nurses in the Durban area live fifteen miles and more from the hospitals at which they work. If they do not own private transport, and, therefore, depend on the public transport system, they may spend up to four hours per day travelling. The public transport system is not only unreliable, it may also be downright unsafe, since African nurses are widely reputed to earn good salaries and are, therefore, obvious targets for the armed thief. But travelling on buses and trains is also uncomfortable, and distasteful to the nurse because of the crowded conditions. It is not surprising, then, that the avowed ambition of African nurses, married and single, is to own a reliable car.

One obvious consequence of the hours that she spends travelling and working, is that the nurse has very little time to devote to her home and family. But it remains her responsibility to see that her domestic duties are fulfilled satisfactorily, and this entails employing a domestic servant[1]. The servant is the nurse's financial liability, since she undertakes the domestic duties that the nurse, as wife and mother, should be doing herself. If the servant is a young teenager, the nurse will pay her between R6.00 and R8.00 per month. If she is a mature woman, she will get an average wage of R10.00 per month. Such wages amount to pocket money, since the servant lives with the family and shares their food.

The effects on the children, of the working nurse's absence from home, are regarded as being dependent upon the quality of the domestic servant. If the maid follows the nurse's instructions in the matters of discipline and feeding, then the nurse may regard her own absence as being at least partly beneficial, in that the children appreciate her presence far more on the

[1] See chapter five.

occasions when she is home, than they would if she was there all the time. But if the maid cannot be trusted to keep the children off the street, see that they are fed properly (particularly infants on formula milk feeds), and otherwise neglects her duties in favour of visiting around the neighbourhood and entertaining undesirable (non-elite) friends in the nurse's own home, then the nurse worries about the effects her absence may have on her children's development. The nurse's biggest fear is that her maid will neglect the proper feeding of her infant, for to have her own child admitted to hospital suffering from a nutritional disorder, is the greatest disgrace any African nurse can imagine befalling her.

In exchanging her domestic duties for economic function, the married nurse has largely relinquished the duties that, in traditional society, comprise the role of wife. As a trained nurse, she expects and is expected to work and contribute to the family income, especially if she is to be able to live in accordance with her own expectations and desired standard of living. Hence her role as an elite wife is predominantly, even primarily, economic. And even though her children may be more neglected in terms of parental time devoted to them, than some of their age-mates of non-working mothers, and most European children, they do have greater material advantages than most other children in the African population: they live in well-furnished homes, wear good clothes, eat nutritious food, and are assured of the best education available. All of these advantages, of course, hinge on the family's relative financial well-being.

Financial Arrangements in the Home.

When the wife is contributing approximately half of the total household income, this obviously has important effects on marital

relationships and the balance of authority within the home. The nurse is not financially dependent upon her husband, and this fact results in husband-wife relationships rather different from those expected, traditionally, in African society. The egalitarian behaviour patterns of husbands and wives among the elites, are seen in the situation where the entire family eats together, where husband and wife share their leisure activities, including playing with the children and supervising their school work, and where the husband frequently undertakes the chore of marketing for the family's needs. Thus the saying "Marry a nurse and you've hit the jackpot!" (which is idiomatic in the African community), is merely one side of the coin, and it takes little account of the behavioural re-orientations involved in such a marriage.

As far as domestic budgeting is concerned, most African nurses appear to be involved in one of two situations. In the first, financial policy is determined jointly by husband and wife, each of whom assumes responsibility for certain standard items of expenditure, while all surplus money is pooled in a joint savings account (a bank or building society account, not a Post Office Savings Account, which is regarded as suitable only for uneducated labourers). In this situation, each spouse knows the exact income of the other, all financial affairs are considered to be their joint responsibility and interest, and all decisions on capital expenditure, from their joint savings account, are taken together. Usually the husband assumes responsibility for the rent, electricity, and all food bills, plus school fees and books, and running expenses on the car when one is owned. The nurse furnishes the house, clothes the family, pays the maid, and meets day-to-day expenditure on food items.

Alternatively, the nurse and her husband may follow the second pattern of household budgeting, in which financial responsibilities are allocated as

above, but neither partner knows the precise details of the other's income or expenditure. It would appear that the more popular form of family budgeting is the first, but a number of nurses prefer the second pattern.

In addition to these two types of budgeting, there is a third, which only one of my informants followed. Her husband had handed over to her complete responsibility for the family's financial affairs. Each week he gave her his total pay-packet, and accepted from her a stipulated sum for his own personal use. This particular couple had found that the husband had tended to mismanage his responsibilities while they had followed the first pattern of budgeting, described above, and the ensuing quarrel resulted in his handing over to his wife complete responsibility for banking and everything else. While she was in complete control, he could not be held responsible for any shortages! To what extent this latter type of household budgeting may be more widely practised, I do not know. Nurses are extremely reticent about their financial affairs, and the delicate issue of income and expenditure details jeopardised my relationship with at least one of my regular informants and affected the progress of my research at the hospital at which she worked[1].

As far as I could ascertain, there appear to be no correlations between these different patterns of household budgeting, and the educational standards or occupations of the nurses' husbands, but the data that I have are not statistically significant. It would appear, though, that the nurses' pre-marital savings patterns and use of banking facilities do influence financial arrangements, as would be expected. All of the different budgeting patterns demonstrate the influence of the nurse-wife in the family's financial affairs. She is not expected to take what she is given without

[1] At the 1970 Congress, immediately prior to the discussion on salaries, a delegate requested that the reporters present should treat the proceedings as confidential: nurses do not wish the African public to know exactly how much they earn.

question, and make it stretch to cover all requirements: rather, she may be regarded as co-director of family and household affairs. Financial management is yet another instance of the difference between the traditional pattern of male authority and female obedience, and the egalitarian relationship which exists between nurses and their husbands.

The Ideology of Independence among African Nurses.

Because of her professional status, the African nurse is expected, and herself expects to be "independent". Not only financial independence is involved in this idea, but what one might term an "ideology of independence", which is reflected in the attenuation of interaction with kin in favour of a few, carefully selected friendships, the emphasis on a nuclear family structure, and rejection of the traditional authority role of affines. But this independent attitude goes still further, and affects the husband-wife relationship as well: one example of the nurses' independence has been seen above, in the discussion of financial arrangements between nurses and their husbands.

Perhaps one of the reasons for the nurses' independent attitude, lies in their belief that African men, in general,

> "...are not yet as far up as the nurses. They are not so well educated. This conflict that our generation has, we hope it will not affect our children, because they will have been brought up in a civilised way...Let us look into the future. Say that, in twenty years' time, N____ (her daughter) would marry M____ (her staff nurse neighbour's son). She will not have the problems that I have, because she will marry a man who has been brought up in the same way, to appreciate the same things. So you see, I am fighting to bring L____ and N____ up as 'spoilt Bantu'...!! I grew up in a mud hut in the country, but I am absolutely determined that they will be brought up decently."

In terms of school education alone, however, the nurses' belief that African men, including their husbands, are less well educated than themselves, is somewhat inaccurate, as table 10 shows.

TABLE 10. Educational qualifications of African nurses and their husbands.

Educational Standard	Nurses	Nurses' Husbands
post-matriculation (university or other training)	2	28
teaching qualification	22[1]	24
matriculation	39	37
form IV	6	5
junior certificate/form III/ standard 9	143	47
form II/standard 8	13	11
form I/standard 7	1	7
standard 6 or lower	-	10
unknown	-	1
TOTAL:[2]	226	170

Furthermore, questionnaire results show that eighty-one (81) husbands hold higher educational qualifications than their wives, while forty-six (46) have attained the same educational level as their wives. Only 24,7% (42 of 170) have had less schooling than their wives. But as I have mentioned previously, the quality of education differs between the two groups. As a result of their nursing training, the nurses are firmly committed to a system of values based on those of the West, whereas their "less educated"[3] husbands are not. And it is this situation, as the nurses see it, that gives rise to the problems they experience in marriage, since their own expectations differ from those of their husbands. To live in a house that has no running water; to brew beer in accordance with the traditional role of wife; to

[1] Acquired before commencing nursing training.

[2] The educational status of all questionnaire respondents is given, regardless of their marital status, hence the discrepancy in totals for the two groups.

[3] In this context, "less educated" could be regarded, perhaps more accurately, as "less westernised".

slaughter for the ancestors; to insist on having sons in the family -- none of these ideas finds ready acceptance among nurses, but their husbands may well expect such behaviour. The nurse may, then, be involved in a conflict of ideas, values and behaviour with her husband, and because of her earning power, can afford to follow her own inclinations. The (cultural) conflict of values, plus her financial security, enables the nurse to emphasise the fact that she can, and if necessary, will "go it alone". Her independent attitude is quite evident.

African nurses regard themselves, and would appear to be regarded by most African men, as "westernised" to the point of being "Black Europeans": they may actually be called this as a form of abuse by African men. The material technology of "western" culture is regarded, by nurses, as essential for decent living, but it may be regarded as ostentatious and unnecessary luxury by African men in the non-elite category. This is probably the reason why the nurse assumes financial responsibility for furnishing the house and clothing the family: she can pay for what she demands, while the man concerns himself with the essentials of rent, food[1] and transport. Obviously, the above generalisation applies primarily -- but not solely -- to the less well educated of the nurses' husbands, and by no means to all of them. However, there is often conflict between husband and wife over their respective assessments of what constitutes the minimum basis for decent living.

Given, then, the situation of conflicting values, the feeling of generalised superiority over men on the part of nurses, and their financial

[1] In this respect, it is worth noting that the task of feeding the family, in normal circumstances, falls to the woman in traditional society, since she is responsible for the cultivation of the staple crops. Hence the allocation of financial responsibilities found among African nurses and their husbands, as members of the elite stratum, reverses the accepted pattern found among traditionalists: I am indebted to Mrs. Harriett Sibisi for drawing this distinction to my attention.

security, it is hardly surprising to find what I have termed the ideology of independence among them. If the nurse feels so inclined, she can literally tell her husband to "go to hell", and mean it. Or she can make his life so unpleasant that he will leave her. For part of this ideology of independence involves the idea that a husband is an expendable luxury, and if he causes the nurse more trouble than he is worth, there is no point in continuing the marriage. Any African nurse, regardless of age or marital status, will assert that nurses' marriages do not last, and that there is a higher rate of marital break-up among nurses than is found in any other section of the African community -- because nurses are independent, and do not stand for nonsense on the part of their husbands. The supposed high rate of marital break-up is indeed one reason given by single nurses to explain why they are in no hurry to get married.

The difficulties nurses experience with their husbands are usually concerned with two major problems: alcohol and women. Although it is deprecated as leading to "uncivilised" behaviour, drinking in itself is considered to be (barely) tolerable. But what is not tolerated is the physical assault that often results from the excessive consumption of alcohol. A drunken husband is quite likely to beat his wife, especially if there have been previous disputes between them. Such behaviour is quite frequently reported in African newspapers, and is a prime cause of the majority of divorces involving African nurses.

Extra-marital relationships carried on by nurses' husbands are the second major cause of marital friction. To a large extent, if such relationships are conducted surreptitiously, and do not affect the husband's financial responsibilities to his family to any noticeable degree, they can be ignored. But, I am told, some husbands will bring a mistress into the home

deliberately in order to humiliate a wife who is a nurse. In this case, his behaviour cannot be ignored, on account of the two-fold slight it involves, to the individual wife, and to the wife as a representative of the high-status, elite group of professional nurses. Thus such behaviour, in the same way as physical assault, is likely to lead to separation or divorce, for the nurse cannot afford to let the matter drop, without losing status by allowing her husband to treat her in this way. In these situations, she must assert her independence in order to retain her status.

It does seem possible that these problems arising from the intake of alcohol and adulterous relationships, may result, at least partially, from the nurse's elite position, which gives her a higher status than her husband, in most cases. If one considers that only 25,9% (42 of a total of 170) of questionnaire respondents' husbands were employed in what I have classified as professional occupations, including teaching, the status differential in the occupations of nurses and their husbands, becomes quite evident.

TABLE 11. Occupations of the husbands of African registered nurses.

Professional:			
	lawyer	4	
	health educator/medical aide	4	
	medical technologist	3	
	social worker	3	
	minister of religion	2	
	school inspector	1	
	registered male nurse	1	
	lecturer	1	
	private secretary	1	
	teacher	22	TOTAL: 42
Clerical:			
	clerk	43	
	public relations officer	2	
	cashier	1	TOTAL: 46
Sales:		20	
Driving Occupation (bus or taxi):		22	
Independent Business:		5	
General Labourer:		10	
Other (including 7 policemen):		13	
Unemployed:		2	
No Information (widowed/separated/divorced):		10	GRAND TOTAL: 170

In this situation, where the woman has a higher status than her husband, in most cases, against the background of the patrilineal expectations of African society, the man's behaviour is, perhaps, explicable in the following terms:

> "I think the problem is that most nurses' husbands have a complex about a woman having such a responsible position, and a high salary, because we will not just listen to them in everything. They are not prepared to accept that we are emancipated now." (This particular informant had divorced her husband less than one year after marrying him, on the grounds of repeated physical assault.)

It may be seen, with reference to these problems of alcohol and adultery, that nurses and their husbands have differing expectations regarding what is appropriate behaviour. African men, traditionally, were not expected to be monogamous. Even today, nurses readily admit that "men are weak" and find the confines of monogamy irksome, and many nurses accept that their husbands will inevitably look for sexual satisfaction outside of marriage. Their tolerance of this situation extends only to a limited degree, however, beyond which "polygynous" behaviour will result in the dissolution of the marriage. And whereas beer is an essential part of traditional social life, the modern drinking patterns of African men -- which may, perhaps, be regarded as an extension of the traditional situation -- are unacceptable to most African nurses. When the man combines extra-marital relationships with drinking to excess and wife-beating, his nurse-wife will reject such behaviour totally, and sever the bond of marriage. Her elite values do not coincide with his neo-traditional outlook, in such situations.

Marital Instability: Myth and Reality.

During the course of my research, I was told by all of my informants, without exception, that "nurses' marriages don't last". Yet it took me some

months to find just one divorced nurse, though I did find innumerable marital problems. This situation puzzled me, to the point of wondering whether the widespread belief in the inevitable collapse of marriages among African nurses was, in fact, objectively valid -- or was it a modern myth? The postal questionnaire used in the later stages of the research was intended, *inter alia*, to shed some light on this interesting issue.

It would seem, from the questionnaire results, that the number of marriages that do collapse, is small, and certainly nowhere near the proportions quoted by my informants. As may be seen from table 12, less than ten per cent (17 of a total of 172) of all the marriages ever contracted by questionnaire respondents, ended in separation or divorce. When finalised divorces alone are considered, these constitute only 7,6% of all marriages ever contracted[1].

TABLE 12. Proportion of marriages among African nurses in different age categories, which have dissolved as a result of separation or divorce.

Marriages:	Under 30	30 - 40	40 - 50	Over 50	TOTAL
A. total number of marriages:	36	85	43	8	172
B. ending in death:	2	5	5	0	12
C. ending in separation:	0	2	1	1	4
D. ending in divorce:	0	5	7	1	13
E. $\frac{(C + D)}{(A - B)}$:	$\frac{0}{34}$	$\frac{7}{80}$	$\frac{8}{38}$	$\frac{2}{8}$	$\frac{17}{160}$
F. E expressed as a percentage:	0%	8,75%	21,05%	25,0%	10,6%

From table 12, it may be seen that there is an increase in the percentage of marriages ending in separation or divorce, with increasing age,

[1] African divorce court records suggest that 6% of all civil and church marriages, in the African population, end in divorce.

suggesting that the risk of marital dissolution increases either with the increasing age of the nurse, or with the number of years that the marriage does last, or both. This increase is steady and significant, even though the very few cases in the oldest age category may not be statistically acceptable or reliable. Even given this steady increase in the rate of marital dissolution, however, the average number of marriages ending in separation or divorce is still less than ten per cent of the total number of marriages.

The questionnaire was constructed to include a check on the suspected low rate of marital break-up, since it was considered possible, if not likely, that there might be a high rate of effective marital dissolution, even if relatively few marriages actually collapsed into legal divorce. Thus a question covering all periods of residential separation was included, and it transpired that in 27,3% (47 of 172) of marriages, there had been at least one period of temporary residential segregation which, as far as is known, has not resulted in permanent separation. Certainly, in these cases, the nurse still regarded herself as married, not separated, in terms of marital status.

TABLE 13. Periods of temporary residential separation in 172 marriages among African registered nurses.

Period of Separation	Number of Marriages Involved
never separated:	96
less than six months	8
six months to one year	5
exactly one year	11
between one and two years	8
more than two years	15
(marriages ended in death, separation or divorce)	29
TOTAL: 172	

It may be assumed that those nurses who were separated from their

husbands for exactly one year, were involved in post-basic study courses away from home: in most cases, this would be for midwifery training. At least two of those who were separated for more than two years, did their entire nursing training after marrying, but were required to live in nurses' homes during their training. In one further case, the husbands political detention on Robben Island has resulted in a four-year separation. Thus, if the above cases are excluded, only 33 of the 47 cases of residential separation detailed above in table 13, may be cases of effective marital break-up. This means that a maximum of fifty (50) marriages, or 29,1% of the total number of marriages ever contracted by these respondents, may have ended as a result of separation, divorce, or effective permanent residential separation, even though, in the last case, the nurses still regarded themselves as being married. As against this figure, ninety-six (96) marriages have never involved the nurse and her husband in any period of residential separation[1].

From this evidence, it would appear that the nurses' own belief that 60-70% of nurses' marriages have broken up and ended in divorce or separation, is not objectively valid, even given the widespread existence of marital problems, discussed previously. Why, then, should this myth exist?

The belief that "nurses' marriages don't last" may be used by an African nurse, to legitimise her stand of independence vis-à-vis her husband, and also to insist on her own minimum standards in the home. If her marriage should come to an end, then, this is not seen as cause for individual shame and blame: for, in terms of the myth, it was only to be expected that the marriage would not last. Thus one informant[2], married to a matriculated clerk, justified the failure of her marriage with reference to this myth, when she

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[1] It should be noted here that husbands who are sales representatives may be required to travel away from home at regular or irregular intervals, but such travelling cannot be classified as "temporary residential separation" in the sense in which I have used this term.

[2] See chapter eight: "Elizabeth".

flatly refused to go and live in a two-roomed "shack" which had crumbling walls and no running water. Her husband wished her to leave the semi-detached flat she was renting, in order to save money to build their own home. He refused to live on the mission with her, and she refused to move to his "shack", telling him that if he expected her to act thus, he could consider their marriage over and get out. She was supported in her stand by her elder brother, himself a headmaster of an urban secondary school, and a member of the elite stratum. In fact, this brother urged her to commence divorce proceedings against her husband (who did leave) on the grounds of desertion! Afterwards, she had this to say:

> "Look, I wanted very much to have a happy, settled family life, and to set an example, especially to young nurses, because nurses' marriages don't last. But when E____ came with this nonsense about moving to C____, to that filthy shack he calls a house, then that was too much. How could I bring my children up in such a place? Not only for myself, but for their sake I will <u>not</u> live in that shack...Even though I still love him, I am not prepared to give in to him on this point. <u>I will not budge an inch</u>! So — he has left. And I miss him, but really, I do not feel ashamed about what has happened. As a nurse, I must expect these things."

Because of her (potential) financial independence, the nurse need not continue an unsatisfactory marriage, for she is able to support both herself and a small family on her own salary. The status aspects of marriage (which were discussed in chapter six) are satisfied once the nurse has been married in church, at much expense, and has born a child, thus demonstrating her fertility. Once these requirements have been met, the major goal of marriage has been achieved, and should the marriage flounder later, there is no reason why she, the nurse, should sink with it. Most important of all is the fact that the children <u>must</u> be brought up in accordance with her own ideas and values. Where her values clash with those of her husband, she must ensure that her children are clean, properly fed, adequately clothed and educated, so that they grow up in an environment that accustoms them to the western-based

elite life style. Her primary responsibilities are to her children: her husband is already adult, and if he is incapable of looking after himself as he should, then that is not her problem, but his.

In the light of the problems experienced by nurses in their married lives, and the existence of this myth which may be used to justify marital dissolution, how does it happen that such a large proportion of nurses' marriages do hold together, in many cases apparently happily? Before attempting to answer this question positively, it is necessary to examine the material in order to dispose of certain negative factors, or factors that do not, apparently, work either toward or against marital break-up.

Examination of the data available for the seventeen cases of legal divorce or recognised separation, yields little conclusive evidence regarding the part played by the educational qualifications and/or occupations of the nurses' ex-husbands. The distribution shown in table 14 does not differ significantly from the figures given in tables 10 and 11 for husbands' educational qualifications and occupations respectively.

TABLE 14. Educational qualifications and occupations of African nurses' husbands, in cases of separation and divorce.

Educational Qualification		Occupation	
post-matriculation	1	professional	2
teaching qualification	2	teaching	2
matriculation	5	clerical	4
form IV	1	sales	2
junior certificate	4	labourer	2
form I/standard 7	1	policeman	1
standard 6	2	unknown	4
unknown	1		
TOTAL:	17	TOTAL:	17

In eleven of these cases of separation or divorce, the husband had equivalent or higher school education than the nurse; in five cases the nurse's school education was higher than that of her husband; and for the remaining case the information was not given. It would appear, then, that the termination of marriage is unconnected with the man's schooling or occupation, and there is no significant clustering within the ranges of these two factors.

There does appear to be some relationship between the nurse's age at marriage, and later dissolution of the marriage, however, although it is impossible to do more than indicate potential relationships in view of the small numbers involved. In the seventeen cases ending in separation or divorce, seven marriages were contracted by nurses who were less than twenty-four years of age (42% compared with approximately 33% of the figures for all marriages) and five more were contracted after the age of thirty (30% compared with less than 20% of the total figure.) It would seem, then, that both early and late marriages ages increase the likelihood of later separation or divorce.

Finally, the barely significant correlation between non-payment of lobola and later marital break-up, has been shown previously[1].

The most positive association seems to be between age at marriage and the later failure of that marriage, and this factor exists in western societies as well as among African nurses and would, therefore, appear to be of little specific explanatory value in this context.

Thus it seems possible that the majority of marriages contracted by African nurses, probably continue as a result of the nurses' occupation and

[1] See chapter six, page 120.

elite status. Nursing salaries are relatively high by African standards, in South Africa, especially for women, and her professional qualification more or less assures the nurse of a job anywhere, at any time. Marriage to a qualified nurse, then, represents a form of security, insurance even, to the average, non-professional African man. Thus the husband has a vested interest in continuing his marriage to a nurse, in spite of the problems he may encounter in such a marriage. In this situation, he is unlikely to divorce his wife.

There appears to be some support for this point of view. From the cases of one divorce and one separation among my respondents, and two newspaper reports of divorces involving nurses, it would appear that the nurses themselves are responsible for the divorce suits. In all four of these cases, the nurse has been plaintiff, suggesting that divorce is, perhaps, more frequently the result of nurses' dissatisfaction with their husbands, than vice versa. This evidence lends support to the idea that, in cases of conflicting values between a nurse and her husband, it is in the nurse's interests to sue for divorce, and in the man's interests to continue the marriage, even if this means toeing the line his wife lays down. Paradoxically, then, the nurse's elite status resulting from her professional position, works both for and against the continuation of her marriage to a non-professional, non-elite man, and in the final analysis, it may well depend on personality factors as to whether any particular marriage is continued or dissolved.

As an incidental point, it is perhaps worth noting that, in cases of marriage under common law, if an African woman sues, successfully, for a divorce from her husband, any lobola that may have been paid, is not returnable. This may be one reason why a nurse's kin, especially in the rural

areas, will accept a divorce instead of pressing for the continuation of the marriage: they do not stand to lose by such a divorce. Once again, this situation reflects the nurses' distinctive social position, for relatively few African marriages are recognised as valid under common law. Most African marriages are recognised in terms of tribal law only, where the lobola payment, far from being regarded as a peripheral detail of no legal significance, is the factor that legalises the marriage, and actually constitutes the marriage in legal as well as social terms. It is possible, then, because nurses conclude marriages under common law, to regard the nurse's behaviour in marriage, as being beyond the reach of traditional sanctions, and this legal position buttresses her elite status.

In conclusion, the issue of marital dissolution among African nurses, may be summed up as follows. In keeping with their elite status, nurses contract (monogamous) marriages under Roman-Dutch (Common) Law, either by civil rites or in a religious ceremony. This legal status of their marriages means that the considerable sums of money paid as lobola for nurses, are non-returnable by the nurses' kin, should a nurse sue, successfully, for a divorce from her husband. Thus in the event of the dissolution of the marriage, the important traditional sanction of return of the lobola, has been removed. Thus the incentive for the woman's kin (to whom the lobola is paid), to press for the continuation of the marriage, is removed. In addition, the nurse herself is financially independent of her husband, and can, therefore, afford to discontinue the marriage. Furthermore, there exists, among African nurses, a myth (that "nurses' marriages don't last") which excuses, if not justifies, the dissolution of their marriages. But despite these factors, few nurses' marriages actually do dissolve, and the reason for this continuation probably lies in the security offered by a nurse-wife to non-professional, non-elite African men.

CHAPTER EIGHT

THE LIFE HISTORIES OF THREE AFRICAN NURSES

In previous chapters, I have dealt with the implications and consequences of the elite status of African nurses, in general terms. I now wish to consider some of these points in relation to the lives of particular individuals, in order to provide a more complete and more realistic picture of what this elite status may entail for the individual nurse. Therefore, I have included, in this chapter, the life histories of three of my regular informants. Each of these three Zulu women lives a different life, under different circumstances, with different interests, yet there is a common theme linking all three: each shows different facets of elite status, within the overall framework of elite identity.

Case A. Elizabeth.

At the time of research, Elizabeth was thirty-five years old (she was born in 1935). She is separated from her husband, and lives with her two young daughters (aged, at the time, three years and a few months, respectively) and her maid, in a mission-owned house. At the time I knew her, Elizabeth was working in the operating theatre of St. Mary's Hospital.

Elizabeth holds three nursing qualifications, in general nursing, midwifery and operating theatre technique. She trained, initially, at the Benedictine Hospital, Mongoma (a Catholic mission hospital) and, later, at Edendale Hospital, outside Pietermaritzburg.[1] She has worked at Mongoma,

[1] Until April 1970, Edendale Hospital was controlled by the Natal Provincial Administration: it is now under the control of the Department of Bantu Administration, since it is situated in a Homeland area.

Eshowe, Port Shepstone, Pietermaritzburg and Durban, in both mission and provincial hospitals. Like most of her colleagues[1], Elizabeth has been exposed to the influence of a number of different hospitals. In all, she has moved between different hospitals nine times, in response to the demands of post-basic training, her mother's illness, a desire to work in provincial hospitals and, finally, the desire to settle down in order to raise her family.

As may be seen from her genealogy (Case A: Elizabeth's Genealogy), Elizabeth was the third child and only daughter born to her parents. She is the youngest in her sibling group. Her eldest brother, who failed standard seven at school, is a police detective, who lives in Umlazi and works at Isipingo (on the South Coast). He is married to an ex-domestic servant, though their only son was five years old before they eventually married. Elizabeth's second brother obtained his Higher Primary Teachers' Certificate before leaving school, and went on with his studies through correspondence schools. Eventually he graduated with a Bachelor of Arts degree from the University of South Africa. He is married to an ex-teacher, and they have six children.

Elizabeth's mother was brought up as a practising Christian. Her father (Elizabeth's maternal grandfather) was an assistant to a Methodist (European) minister. Elizabeth's maternal grandmother died two months after the birth of her sixth child, and Elizabeth's mother (the second child and eldest daughter) was left to raise her younger siblings, and thus had to leave school before completing standard two. But she had worked for intermittent periods as a domestic servant on European farms, and had thus become aware of the importance of being able to understand and speak English, and she

[1] Cf. table 1, p. 4.

determined that any children she might have, would be educated. When Elizabeth's mother had discharged her obligations to her younger siblings, she married, in 1928, at the age of thirty-seven.

Elizabeth's father came from a pagan family. Both of his parents were pagan for the greater part of their lives, though his mother (Elizabeth's paternal grandmother) was converted to the Methodist church in middle age, and all of her children were baptised in the Methodist church when she joined it. According to Elizabeth, however, they were nominal Christians only, despite their western dress. In her old age, Elizabeth's paternal grandmother came under the influence of Isiah Shembe, and left the Methodist church to join the Shembe sect. Elizabeth's father, who never attended school as a child, left the country at an early age, to work in Pietermaritzburg. Here he attended night school, where he completed standard two successfully. Eventually he became an induna with the South African Railways Police. He died in 1957, in Pietermaritzburg.

It may be seen, then, that although Elizabeth comes from a predominantly Christian background, virtually all of her immediate kin are semi-literate and, with the exception of her second brother and his wife, non-elite. As I have described in chapter five (pp. 98 - 103), the pattern of linkage of nurses to non-elite kin, is common. The non-elite family background is indeed one important reason why, in the case of elites in modern Africa, analysis of their position in terms of the concept of social class, is premature.

For the first few years of her life, Elizabeth's activities did not differ from the traditional Zulu rural pattern to any great extent. On the farm at Camperdown, and later at Umzumbe (on the South Coast), she fetched wood and water like any other Zulu girl. However, her Christian background

became significant when Elizabeth was old enough to attend school. Until the end of standard five, she attended the Umzumbe Mission School, which was run by the Free Methodists. Her mother then wished her to leave school, fearing that she would become "spoiled" by further education, and neglect her parents in favour of town living. However, as a result of the combined protests of Elizabeth's eldest brother (who had himself left school after failing standard seven) and her young Xhosa (female) teacher, her mother was prevailed upon to allow Elizabeth to continue with her schooling, which she did at one of the better-known Catholic boarding schools, St. Joachim's, at Umtwalume (also on the South Coast). Elizabeth failed her Junior Certificate once, but was sent back to school to repeat that year and pass, which she did in 1953. Beyond standard five, Elizabeth's education was financed by her eldest brother alone.

Elizabeth's parents expected her to become a teacher, as had her second brother. However, she eventually decided to enter nursing, partly as a result of the influence of the nuns who taught her at St. Joachim's, but also because of the objective advantages nursing offered over teaching as a career, such as pay during training, uniforms, no tuition fees, and work in a modern hospital rather than among "raw" people in the bush. In 1954, at the age of nineteen, Elizabeth began her nursing training at Nongoma. Because she failed the South African Nursing Council Preliminary Examination (at the end of her first year), her training extended over four years. Elizabeth was registered as a trained general nurse, with the South African Nursing Council, in May 1958, at the age of twenty-three.

In the early nineteen-sixties, Elizabeth came into contact, for the first time, with people who regarded her primarily as an African rather than as a trained nurse. At Port Shepstone, for example, she lived with other

unmarried nurses in the Non-European Nurses' Home, which was an old house. Her request that the filthy, torn curtains in her room be replaced, was met by the (European) caretaker's reply: "Who does she think she is? A European?" The food served to the African nursing staff consisted largely of samp and mealie porridge, because "they don't eat anything better at their homes". Such attitudes came as a surprise to Elizabeth, who had had extended contact, from her earliest schooldays, with missionary Europeans "who were trying to uplift the Africans". In view of these experiences, it is hardly surprising that today Elizabeth distinguishes very clearly between Europeans who are "white" and those who are "white-white". (This latter category encompasses all those Europeans who display overt racial prejudice.)

While she was single, Elizabeth went out with many different men, a fair number of whom apparently expressed interest in marrying her. She is somewhat unusual among nurses, however, in that she prides herself on having kept all of them as friends and nothing more, not having entered into sexual relationships with any of them, "... so that today, I can look any one of them in the eye and not feel ashamed".

However, Elizabeth did eventually marry, at the fairly late age of thirty-one, and thus put an end to her family's speculation: "... they were always wondering who I would bring home and say 'We are getting married'". She had met James in 1962, through the machinations of a mutual friend (also a staff nurse), and they decided to get married in 1963. James could not find sufficient money to meet the lobola demanded by Elizabeth's eldest brother (who became her guardian after her father's death). Elizabeth and James quarrelled about this question of lobola, and parted. Three years later, however, James contacted her again, and they decided to marry after all. This time, James could and did provide the R500,00 requested by Elizabeth's eldest

brother. In fact, the amount agreed upon was R560,00, but it was decided, by Elizabeth's brother, that the last R60,00 should be regarded as the presents which she should, according to Zulu custom, have given to James' relatives, and this sum was, therefore, cancelled. Part of the lobola was used to cover the wedding expenses, while the remainder was kept by Elizabeth's eldest brother, who had financed her schooling from standard six, supplied her with pocket money, and paid her travelling expenses during her nursing training (her salary, as a student, was so low that she could not meet the exponse of travelling by train and bus from Umzumbe to Nongoma).

In general, Elizabeth approves of the lobola custom, since she feels that it acts as a curb on the polygynous inclinations of men.

> "And how else can you believe a man if he says he loves you, at that time? Only if he is prepared to make sacrifices to pay lobola."

However, Elizabeth strongly believes that the present form of lobola should be altered, so that the girl herself should have the final say regarding the distribution of the money, which she thinks should be used to cover the wedding costs, while the remainder (if any) should go to those who have raised and educated the girl. However, she objects very strongly to the practice of charging an "education fee" as part of the lobola: "That is trash -- rubbish!" Thus, although Elizabeth accepts this African custom, it is obvious that her ideas regarding the form this should take, differ quite radically from those of most Africans.

When agreement regarding the lobola had been reached, Elizabeth put on the engagement ring which James had bought in 1963, and which they had had blessed, secretly, at a private ceremony. Elizabeth's mother had kept this ring for her daughter, following Elizabeth and James' quarrel. They did not

hold a formal engagement party.

Elizabeth described her wedding, which took place at Umzumbe in September 1966, as a "two-session affair", which catered for two different groups of people. Thus Elizabeth's wedding followed the general pattern of nurses' marriages discussed in chapter six. The Catholic mission church was packed with Africans and Europeans alike. The guests came from Elizabeth's home (her brother had hired a bus to transport relatives), from the mission, the school, and the hospital in Port Shepstone, where she was working at the time. Two of her four flower girls were the daughters of a European nursing colleague (reflecting Elizabeth's fairly extensive social contact with Europeans), and the other two were the daughters of her second brother. Her bridesmaids were both classificatory kin, one a staff nurse, the other an auxiliary nurse at Port Shepstone Hospital. Elizabeth herself (to judge from her wedding photographs) was a happy, even smug, bride!

After the Nuptial Mass had been celebrated, the first "session" of the celebrations was held. The guests proceeded to High Tea in the Convent Hall, and this reception lasted for just over an hour. Tea, sandwiches and cake were served, and the wedding cake was cut. (Elizabeth kept the top layer of the three-tiered cake, for the anticipated Christening of her first child.) This High Tea catered for the educated, professional friends, African and European, of the bridal couple. All of the proceedings, including the speeches, were conducted in English.

When High Tea was over, and Elizabeth and James had signed the marriage register, the proceedings moved to Elizabeth's home, three miles away in the country, where the second "session" of celebrations was to be held. As she stepped out of the bridal car, Elizabeth was called upon to dance: a few

shuffling steps substituted for the traditional dance, and then she pleaded that her long, white wedding gown[1] was impossible to dance in!

Country folk, kin and non-kin, came from far and wide to attend this celebration. They brought beer and food -- samp, rice and bread -- to augment the stocks Elizabeth's brother had purchased. Some four hundred guests were fed from the beasts that had been slaughtered the previous evening: the mula[2] cow, presented as a gesture of honour to Elizabeth, the only girl in a family of boys; a second cow, also in Elizabeth's honour, on account of her good behaviour while in the family; and two goats, one to thank James for the lobola, and the other for the umkhongi in recognition of his services. The food was served by the professional people, the nurses and the teachers, to the rural guests where they sat -- the men in the cattle kraal, the old women in their hut, the younger guests outside, and the wedding party at the table of honour, in a separate hut.

In the late afternoon, Elizabeth and James changed into everyday clothes and left the scene of continuing celebrations. They walked over to the home of one of Elizabeth's classificatory kin, where they spent the night, and were served breakfast in bed the following morning -- an interesting departure from Zulu custom!

On the following (Sunday) afternoon, they travelled by car to Durban. They had supper that night with James' parents (just the four of them), but stayed only for supper. James, at the time, was employed as a (non-elite)

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[1] Elizabeth's wedding dress and accessories, plus the dresses for the bridesmaids and flower girls, cost her R105,00, of which James refunded her R70,00.

[2] I cannot find any mention of such a beast in Krige (1950) or Vilakazi (1965). The name was, however, spelt out for my benefit by this informant, and probably derives from the ukwomula custom described by Bryant (1905:475), whereby a goat should be slaughtered by a girl's father during her puberty seclusion, to ensure her fertility in marriage.

caretaker at a Westville sports club, and was provided with accommodation. Elizabeth stayed with him for a week, on holiday, before returning to work at Port Shepstone.

When she went on maternity leave at the end of May, 1967, Elizabeth went home to Umzumbe to stay with her mother. According to Zulu custom, her first child should have been born at her parental home, but Elizabeth preferred to deliver in hospital. Her first daughter was born by Caesarian section at Port Shepstone Hospital, in late July (1967). After leaving the hospital, she returned to stay with her mother for the rest of her maternity leave.

Elizabeth returned to work in November 1967, to resign her post. She felt that the time had come to settle permanently, and she wished to serve the Catholic missions in some way. Because James was working in Durban, she came to St. Mary's, but this move was not in her own best material interests. She had been a nursing sister at Port Shepstone, and here she had to accept a staff nurse's position, which, in addition to a loss of authority and prestige, also meant a drop in salary.

At first, living conditions were poor when measured against Elizabeth's standards. Three families shared bathroom and toilet facilities, and each family had only two rooms for its own use. However, after some months had passed, Elizabeth managed to secure her present accommodation, a semi-detached "flat" comprising kitchen, lounge, two bedrooms, bathroom and separate toilet, for which she pays a rental of R20,00 per month. Her home is furnished adequately, but not expensively. The furniture, all of which belongs to Elizabeth herself, includes (in the kitchen) an electric stove and refrigerator, a small gas stove (used before their electricity was connected), two kitchen

cupboard units and a panelyte table-and-chairs set; (in the lounge) three occasional chairs and a divan (in place of the more usual lounge suite), a writing table, a nest of coffee tables and a small carpet; a bedroom suite, single bed, cot and two rugs. A portable radio substitutes for the more usual radiogram cabinet. Elizabeth disapproves of using hire purchase facilities, in contrast to most of her colleagues, and her salary allows few luxuries without using credit, hence her home is less impressive than those of most nurses. Her life style is nevertheless that of a member of the elite.

James, the husband from whom Elizabeth is separated but not yet legally divorced, has rarely lived with his family of procreation. James is urban-born and urban-bred, a matriculant with no professional qualification, who has held a number of jobs, clerical and other, since his marriage. At one stage, he was unemployed for some months, and because he had put his savings into fixed deposit with a building society, Elizabeth was solely responsible for family finances, a situation which she did not appreciate. James' frequent changes of job have been a source of dispute in the past, and they illustrate the problems which may be faced by an educated, but professionally unqualified, African man in the South African employment structure. The contrast between James and Elizabeth in terms of their respective job security and earning capacity, is apparent. James earns less than Elizabeth, and she thinks he has "a complex" about this situation.

During the course of my fieldwork, James joined his wife and daughters on the mission, supposedly on a permanent basis. But within months, it became clear that their marriage was finally finished. Why? What caused this break-up to occur? The factors of tension arising from employment and financial issues have already been mentioned, but other factors have important bearing on the dissolution of their marriage, as well.

Elizabeth regards herself as hard-headed and independent, and sees the first of these attributes as a personal idiosyncracy, the second as the hallmark of a nurse. These attributes are apparent in her behaviour most of the time. She refused, point-blank, to live with James' parents under any pretext at any time, before agreeing to marry him. She refuses to have alcohol in her home, with the exception of the odd beer or bottle of wine on celebratory occasions -- let alone brew beer herself. During the fieldwork period, she made use of her pregnant condition to refuse to look after James' father's sister's husband, who was dying of lung cancer at home in Clermont, explicitly denying that her husband's kin had any right to expect her to undertake such nursing duties in addition to her own job. Elizabeth expounded her own attitude in the following words:

> "Look, I am an African. But just because I am an African does not mean to say I must accept <u>everything</u> that is African custom because it <u>is</u> custom. I hold certain principles, and act according to these, and many of these principles do <u>not</u> agree with African custom...For instance, I will <u>never</u>, <u>never</u> brew beer in my house..."

Some of Elizabeth's "principles" derive from her nursing training, while others may be traced to her religion. Elizabeth voluntarily changed her affiliation from the Methodist to the Catholic church in 1955, at the end of her first year of nursing, and she explicitly states that, whatever the appearances to the contrary, she is deeply religious, and her religion means a good deal to her. She attends church daily. Certain logically unacceptable ideas in Catholic doctrine, she refuses to think about, on the grounds that such mysteries of faith are closed to Man's knowledge, and must be accepted without question. Whether such ideas are indeed accepted, is doubtful, of course, and I would suggest that, to a person who thinks as deeply as Elizabeth does on most issues, practical considerations have a bearing on

such acceptance. For instance, the doctrine of the Trinity has theoretical significance, whereas the number of children one has, is an intensely practical issue. In addition to accepting Catholic doctrine, Elizabeth is a nurse, and on some issues (such as the number of children one has), Catholic and nursing values clash among Africans.

> "As a nurse, I see the necessity for being able to feed and educate all the children you have -- this is good. But for myself, such methods (that is, of "artificial" contraception) are not for me, from my religion."

As I have indicated earlier, the majority of African nurses desire and have fairly small families. Non-Catholic nurses, in general, express a desire for small families, whereas Catholic nurses say they would care for "as many children as God sends", though the more forthright ones add "but not happily". Despite the psychological conflict it caused her, one of my Catholic informants actually underwent tubal ligation after having two children (see p. 103). Indeed, Elizabeth herself expressed a desire for four children when she had only one, but when the second arrived, she commented, twice, "I think she will be the last", and merely smiled when reminded of her initial estimate.

Elizabeth's first child was born less than a year after she married. Probably as a result of her residential separation from James, her second child was born three years later. Her most fertile years are past now, but with her husband living with her, and modern techniques of birth control denied to her, Elizabeth could indeed have a fairly large family. Thus her religious principles are, to some extent, in conflict with her values as a nurse, and it would appear to be possible that this conflict may have had some (latent) bearing on the break-up of her marriage, though I do not wish to over-emphasise this possiblity.

The final breaking point in the marriage came when James demanded that Elizabeth relinquish her R20,00 per month mission house, and move from the mission station to his home at Clermont. Her refusal was absolute: the house had two rooms, crumbling walls, and no running water. James proposed that they would save money to build a decent house by living in the present delapidated one, rather than wasting it on a high-rental mission house, however well-appointed and convenient this was for Elizabeth's purposes. Elizabeth refused to consider the proposition, and told him he could either live with her on the mission, or regard their marriage as over. She even called upon her second brother to arbitrate in the quarrel. (Not the eldest brother, who had received the lobola and who is a police detective, but the second brother, the graduate headmaster of a secondary school in the Durban area, and himself an established member of the elite stratum.) He supported her stand, and James packed his belongings and left[1].

Elizabeth regrets the loss of the man she loved sufficiently to marry in the first place, but this loss is less than that which she stood to lose had she acceded to his demands. She has a small family, which she can support, unaided, in the manner she considers necessary for decent, "civilised" living; she retains her elite status, which would have been jeopardised by living in a "shack"; she retains her independence, in accordance with her colleagues' expectations; she has had the status-enhancing white wedding. All she has lost is a husband, not a member of the elite, whose values conflicted, at least in some respects, with her own; and the possibility of a large family, which, while approved by her religion, would have detracted from her elite life style, stretched her financial resources beyond their limits, and limited her "independence", particularly in financial matters.

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[1] See chapter seven, pp. 143-4.

I would suggest that the break-up of Elizabeth's marriage is partly the result of her elite values, the "principles" which guide her actions, and which derive, ultimately, from her professional knowledge and realistic assessment of practical issues. Partly, however, the break-up has been the result of Elizabeth's own personality, for the lasting impression one gains from Elizabeth is strength of character and almost rigid determination. A sense of purpose and rather quiet determination are characteristic of most African nurses, but, as Elizabeth herself admits, she is "hard-headed". Thus where other nurses might, perhaps, have allowed their marital problems to continue, Elizabeth brought hers to a head, and precipitated an open breach of relations between James and herself. It is worth noting that, in her stand against her husband, Elizabeth enlisted the assistance of the only other member of her family who has elite status, despite the fact that the person who receives the lobola is customarily regarded as the "guardian" of the marriage. The very obvious reason for this (since her oldest brother was equally accessible), lies in the differing values of elites and non-elites, discussed previously (in chapter four). Elizabeth knew that her second brother would support her stand on the housing issue, and she also knew that his status was such that her husband would find it very difficult to reject his arbitration and judgement.

While Elizabeth is, perhaps, somewhat exceptional as far as her personality is concerned, much of her background is common to most African nurses. There are obvious similarities between Elizabeth's life and that of another of my informants, Mary-Jane, despite some rather superficial differences, such as their membership of different churches, residence in different areas (mission station and urban township), training at different hospitals, and so on.

Case B. Mary-Jane.

At the time of research, Mary-Jane was thirty-two years old. She was born, in 1938, on an Anglican mission station near Ladysmith, in northern Natal, and was the seventh child and third daughter in her family. Mary-Jane is married and has three children (boys aged eight and seven, and a girl of five). She holds the post of staff nurse at Clairwood Hospital, and looks forward to promotion to the post of sister in the fairly near future. She and her family live in a township house in Lamontville.

As may be seen from her genealogy (see Case B: Mary-Jane's Genealogy), Mary-Jane recognises large numbers of kin, patrilateral and matrilateral, as does Elizabeth. As may be seen from table 4 (on p. 99), these two informants (numbers six and eight) recognised the largest numbers of kin. Through their kin networks, both Elizabeth and Mary-Jane are linked extensively to non-elites.

Mary-Jane's mother, like Elizabeth's, was a rural wife who went no further than standard two at school, although she was born into a Christian family. Mary-Jane's father also came from a semi-Christian family, in that his mother (Mary-Jane's paternal grandmother) had joined the Anglican church, even though her husband did not. The fact that affiliation to Christian churches was less well-established in Mary-Jane's father's family, is reflected in her genealogy: both her father's elder brother, and her father's father's brother, were polygynists.

Mary-Jane's parents are now both deceased. Her mother died in 1966, but her father died in 1940, in Johannesburg, where he worked as a night-watchman. He left his widow with seven young children and an eighth on the way. Only the two eldest sons could assist their mother financially, particularly as far as

the education of the younger children was concerned. But finances were not Mary-Jane's mother's only problem. It appears that there was some pressure exerted upon her, after her husband's death, to enter into a leviritic union with her husband's (polygynist) brother, under the Zulu ukungena custom, for this man ran the homestead and farm. Partly as a result of this situation, and partly because of her large family, Mary-Jane's mother was persuaded by her own widowed sister to join a relatively new and unknown religious sect.

The Assemblies of God had been founded by the Rev. Nicholas Bhengu, in East London. From there, he had extended his proselytising activities to Johannesburg and Durban, and to some smaller centres as well. Mary-Jane states that her mother left the Anglican church to join the Assemblies of God, for two reasons: firstly, she had a large number of small children, for whom (western or non-western) medical expenses would be large, and Bhengu preached that prayer, rather than medicine, was effective in healing. Secondly, to become a staunch churchwoman, in the close-knit organisation that is characteristic of Bhengu's church, was a check on any temptation to become "a loose woman" (Mary-Jane's own phraseology).

Very likely her affiliation to the Assemblies of God was one reason why Mary-Jane's mother continued the struggle to educate her children, for Bhengu emphasised the necessity of education[1]. However, had it not been for her teacher (an African man) at the local school, Mary-Jane would have had to leave school at the end of standard five. This teacher felt that she should continue with her education, and he financed her schooling as far as the Junior Certificate, at St. Hilda's, a well-known Anglican mission (boarding) school, near Ladysmith.

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[1] See Mayer (1963:193 - 205).

After passing the Junior Certificate at the end of 1956, Mary-Jane applied to the McCord Zulu Hospital to train as a nurse. Her eldest sister had trained at this hospital and, as Mary-Jane put it, "nursing was the thing at that time". However, she had to wait at home for six months before the hospital could accept her.

During her training, Mary-Jane made firm friends with two of her fellow students, a Pedi girl from Johannesburg, and a Zulu student from Inanda (Mary-Jane is herself Zulu). She still corresponds with the former, who is now married and settled in one of the smaller Reef towns. These friendships reflect the intertribal pattern found among the majority of my informants. Also during her training, Mary-Jane met the young man who was later to become her husband. At the time, Peter was studying for his matriculation examinations at Adams College, near Amanzimtoti. They met at one of the annual Conventions of the Assemblies of God, in East London, having accompanied their respective mothers to this Convention.

Mary-Jane completed her nursing training, and was registered with the South African Nursing Council, as a general nurse, in May 1961, at the age of twenty-two. Just before the examination results were published, Mary-Jane and Peter became engaged, and held the first engagement party in her home district[1]. She was mocked by her colleagues for contemplating marriage at such an early stage of her career, but two months after their engagement party (when Peter had completed the total lobola payment of R270,00), in late June, 1961, they were married.

The church wedding was held at Mary-Jane's home, where the marriage

[1] See chapter six, pp. 122-3.

ceremony was conducted by the local Baptist minister[1]. An interesting feature of the actual marriage proceedings concerned the signing of the register, in the church itself. As Peter went up, alone, to sign, his four groomsmen and his relatives sang: when Mary-Jane went up, after he had finished, her bridesmaids and relatives sang. After the service was over, the bride's group was adjudged the better in song. This incident has obvious parallels with the competitive singing of the bride's and the groom's parties, in traditional Zulu marriage ceremonies.

After the church ceremony, everybody adjourned to the bride's home, where Mary-Jane and her four bridesmaids (two of her nursing friends, her younger sister, and a classificatory sister who was a teacher), paraded around the homestead for the benefit of the guests. Afterwards the older women took her aside "and lectured me on what a wife must do, and how I must behave and all that. And did they <u>lecture</u>! Hau!" When the lectures were over, Mary-Jane was assisted out of her long white lace wedding gown, and donned a silk suit, hat, gloves and high-heeled shoes. Despite her sophisticated western dress, when the traditional dancing started, she was required to perform alone. "Well, I tried, but I don't think it was very successful!" During the afternoon, meat (from an ox, a couple of goats, and numerous chickens, which had been slaughtered the previous evening) and rice were served to the guests.

In the evening, the reception was held in the school hall, where their engagement party had been held previously. Only cool drinks and light refreshments were served on this occasion, which was primarily for the bridal couple and their educated friends who had attended the wedding. The dancing

[1] Although Bhengu's Assemblies of God is usually regarded as an independent sect, it has close ties of affiliation with both the European Assemblies of God, originating in America, and the Baptist church.

at the reception was of the western, ballroom variety, as opposed to the previous traditional style. In the details of Mary-Jane's wedding, the pattern of dual celebration -- traditional and elite -- is again evident.

On the day following the church ceremony, Peter and Mary-Jane, their attendants, the bride's four brothers and some other close relatives (but not the bride's mother) all travelled from Ladysmith to Adams, for the celebration at Peter's home. Again there was a feast, attended by his kin and others from the area, for which beasts had been slaughtered. However, because Peter's father was already deceased, Mary-Jane states that she was exempted from the traditional behaviour expected of the umakoti: "It was just his brothers, you see, and I already knew his mother from church". The newly-weds spent the remainder of the Sunday at Peter's natal home, but by Sunday evening, they were installed in their own home in Clermont, along with the furniture[1] Mary-Jane had taken with her on marriage (a bedroom suite and a dining room suite. These items have long since been traded in on newer items.)

Shortly after her marriage, Mary-Jane began her midwifery training, again at McCord's, and by the time she had finished the year-long course, she was herself six months' pregnant. Just after the birth of their first son (at McCord's), in September 1962, Mary-Jane and Peter moved into their present house, in Lamontville, which they are purchasing on the municipal "buying scheme". Before they moved in, they had electricity installed at their own expense, and since then they have been improving the four-roomed house as their financial position permits. At the time I knew them, all of the floors had been marley-tiled, the walls were fully plastered, interior doors had

[1] In contrast, Elizabeth took no furniture with her to her new home: "My certificates are my furniture. Later, if we need it, they can earn money for me -- as they have done up to now."

been fitted, and the kitchen walls had been tiled. They had also put in a stainless steel sink and cupboard unit, and there were pelmets above all the windows. Their furniture (bought on hire purchase) is in keeping with the improvements made to the house: a medium-sized refrigerator, stove, panelyte kitchen set, lounge suite, display cabinet, radiogram, main bedroom suite, and twin beds and a wardrobe in the children's room. The house is smaller than Mary-Jane would ideally like, since they have three children and a maid, but they are hoping to buy land and build their own home in Umlazi within the next ten years.

Mary-Jane and Peter are active members of their church, and most of their social activities revolve around their church membership. The fact that she is the only trained nurse in the Umlazi-Lamontville congregation of the Assemblies of God, gives Mary-Jane added prestige within this organisation, since she is often invited to deliver lectures (on hygiene, pre- and post-natal care, artificial feeding, and so on) to her co-members of the Mothers' Union. Mary-Jane is the only nurse I knew who played an active role in the Mothers' Union of her church. She attends these meetings in her nurse's uniform (the others do not wear any uniform), and her knowledge and position are held up as examples to the other women[1].

Their involvement in church affairs has been to their financial advantage. Even though they both contribute tithes amounting to ten per cent of their respective incomes, to the church, Peter and Mary-Jane have responded to Bhengu's exhortations to save their money and make as much as they can by legitimate means. Each year they think up different ways of collecting extra money: in 1970, Peter was collecting old newspapers and

[1] Cf. chapter four, pp. 84 - 88.

reselling these to shopkeepers, while Mary-Jane had bought a large supply of various types of brushes, on a buying order supplied by her brother-in-law (a store-owner in Umlazi), and was selling these to her colleagues at the hospital. They had accumulated over R50,00 from these activities in 1970. The income they gain from these activities is banked in a fixed deposit account, and is used for capital expenditure only.

Because they own a car (a small D.K.W.), Peter and Mary-Jane are fairly mobile. They visit Peter's people at Adams once or twice a month (according to Mary-Jane, the farm is a good supplementary source of fresh fruit and vegetables, thus cutting their marketing expenses). Church activities take up most of their free time, but they do occasionally visit Mary-Jane's two married sisters, who are living in Umlazi, for social, non-religious purposes. Very occasionally they visit her brother (a labourer) and his family, in Kwa Mashu, and perhaps once a year they may visit her eldest sister, who is also a registered nurse, in Pietermaritzburg. Kin links are thus maintained, but Mary-Jane has a number of friends among her colleagues at Clairwood Hospital, where she is presently working, with whom she goes to town and to market, and very occasionally visits.

Like most of her colleagues, Mary-Jane has had trouble, in the past, in retaining the services of a domestic servant (see chapter five). Her last maid walked out one day, giving no notice of her intention to leave, and a fellow member of the Assemblies of God, recommended to Mary-Jane another church member. Nomsa, an illegitimate child who had been brought up by her mother's kin, who lived some twenty miles from Pietermaritzburg, had been neglected, and had never attended school. However, Mary-Jane was desperate for domestic assistance, and employed her. That was some nine months before I met Mary-Jane,

and by the time I knew them, Nomsa (then aged twenty-four) had become quite an accomplished cook, who baked bread every other day in addition to cooking most of the family meals, and even baked cakes and other recipes taken from, among others, Femina[1]. Mary-Jane, who now pays Nomsa R11,00 per month, is so pleased with her that she is considering paying for her to attend night school, for the two boys are already attending school, and have had to be reprimanded severely for mocking an adult who knows less than they do.

As I have mentioned earlier, it seems that a close social relationship, which may even be translated into a kinship idiom[2], is necessary for a domestic servant to remain in the employ of an African nurse. In this particular situation, for example, Nomsa would be foolish in the extreme were she to jeopardise Mary-Jane's trust in her, in view of their common membership of a closed religious group. Likewise, Mary-Jane is bound to treat Nomsa better than she might otherwise do, again because of their common church membership.

In finding a solution to her domestic servant problem, and in having a relatively happy and prosperous marriage (though there have been arguments in the past regarding Peter's association with other women), Mary-Jane is fortunate, and perhaps somewhat exceptional, among African nurses. She attributes her good fortune to the restraint imposed on behaviour by their church: she has been more forgiving than she might otherwise have been, and she feels that Peter has also behaved better than he would had he not been involved in the church. It is worth noting, in this context, that the norms, values and expectations associated with membership of Bhengu's church do not

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[1] A popular women's magazine, written in English.

[2] "We are all brothers and sisters in Christ" is a central tenet of Bhengu's teaching.

conflict with elite values in the way, as shown in Elizabeth's history, Catholic values may clash with those of nurses (on the issue of children and family size, for example). If anything, Bhengu's teachings reinforce elite values: Mary-Jane's knowledge, for instance, is held up as an example to the less educated women in this church. Far from being incompatible with elite values, as is membership of Zionist sects, Bhengu's teachings are such that one could perhaps anticipate an increase in the numbers of elites affiliating themselves to the Assemblies of God. In the East London congregation, according to Mary-Jane, there are a number of trained nurses. In fact, to judge from Mayer's (1963:193 - 205) account, membership of the Assemblies of God could, perhaps, be regarded as training for elite status.

It is quite obvious, from Mary-Jane's life-style, attitudes and values, that she and her family adhere to elite standards, even though she is linked, by numerous and fairly strong ties, to non-elites, both kin and fellow-worshippers. Her kin links to her siblings are reinforced by religious ties, since they all belong to the Assemblies of God. The non-elite status of the majority of Mary-Jane's siblings, is evident from their occupations. Her eldest brother farms the family land, near Ladysmith. Her next two brothers are ordinary unskilled labourers, in Durban and Johannesburg respectively. Her fourth brother runs a shop near Ladysmith. Her youngest sister failed the Junior Certificate, and is simply a housewife, married to a labourer. The sister immediately older than Mary-Jane herself, is an ex-teacher, married to a store-owner, but although this family is relatively wealthy (the "policy" of conspicuous consumption is apparent in their home), they are by no means elites. Only Mary-Jane's eldest sister, who is also a registered nurse, could be regarded as having professional status. As a point of incidental interest, these two nurses stand out, on Mary-Jane's genealogy, as having by far the

smallest living families in their large sibling unit.

Even Peter, Mary-Jane's husband, can hardly be regarded as a member of the elite. Like Elizabeth's (estranged) husband, Peter is matriculated, but without a professional qualification. He is currently employed as a sales promoter for Pro Nutro, with Hind Brothers, and he has a stable employment background. He earns R28,00 per week (R112,00 per month, gross), which is considerably more than Mary-Jane's monthly salary of R81,43 (net).

Their joint monthly income is thus approximately R185,00 net. Peter spends roughly R85,00 of his salary on rent and electricity (R10); groceries (R25); eggs (R3); marketing and meat (R30); church tithes (R11,20); and running expenses on their car (R5-10). Mary-Jane spends approximately R5,00 per month on extra groceries, pays church tithes of R8,41, pays her maid R11, and deals with the family's clothing accounts (at Universe Fashions and Smart Westons, both in Durban's West Street). At the time, the clothing accounts totalled R16,00 per month. She has finished paying off their furniture. In addition to these standard monthly expenses, Peter and Mary-Jane also have irregular educational and insurance expenditure. However, their careful budgeting allows the family to live in comfort, if not luxury. As Mary-Jane put it:

> "Even though we are poor, but still we seem to have a few cents left over each month."

While the details of their life histories vary, it may be seen that the lives and backgrounds of Elizabeth and Mary-Jane are very similar. These two nurses are fairly representative of the generation of nurses who trained in the nineteen-fifties. However, if one looks at nurses who are ten years younger, those who trained during the nineteen-sixties, a different type of background and life history tends to emerge, as is seen in the case of Pauline.

Case C. Pauline.

In many respects, Pauline's history differs from those of Elizabeth and Mary-Jane, for she belongs to a different age group, is better educated (in terms of schooling) and does not have a mission background. Pauline, aged twenty-four (born in 1946), is single, and has a town rather than a country background. She was born in Greytown, the first of six children, to literate parents. Both her Zulu father and her Coloured mother completed standard six at school. Her father is a delivery driver in Durban, while her mother used to work as a shop assistant, but is presently a housewife. With the exception of her immediately younger sister, who is a student nurse at the McCord Zulu Hospital, all of Pauline's siblings are still attending school.

Pauline herself attended the government primary and secondary schools in Greytown, as a day scholar, until she passed her Junior Certificate, at the end of 1962. She then proceeded to matriculation at boarding school in Vryheid, which had been taken over by the State administration from the Swedish Mission, under the provisions of the Bantu Education Act of 1953. A few months before she went to Vryheid, her mother and younger siblings finally joined her father in Durban, where he had been working since 1952. Pauline spent her last few school holidays in Durban.

At the end of 1964, Pauline gained passes at matriculation level in English, Afrikaans, Zulu, History, Geography and Biology. She had every intention of continuing her studies at university, but her parents could not afford to keep her at university and to educate the five younger children at least to the Junior Certificate level as well. Although she applied for one bursary, Pauline was not aware of many others, and when the university year began, she had not found the financial backing to enable her to read for the

social science degree she desired. However, she wanted a professional qualification that would give her a secure occupation even after marriage, and thus decided on nursing, which had the added advantage of pay during training, some of which could be used to assist her parents with the education of the younger children.

Pauline applied to Edendale Hospital for a vacancy, and was told that the hospital had a waiting list extending two years into the future. She then applied to Baragwanath Hospital, Johannesburg, and was accepted to begin training in April 1965. En route to Johannesburg, she shared a compartment with another Zulu girl bound for Baragwanath and nursing, and in the strangeness of Johannesburg, they were glad of each other's company.

Pauline had not expected to find a College of Nursing in a hospital. In line with the stereotype among Africans, she had regarded nursing as a practical rather than a theoretical occupation. However, the unexpected mental activity was most welcome, and Pauline did exceptionally well in her training, gaining Honours in the Preliminary Examination, and again in midwifery, which she also did at Baragwanath. She was awarded a book prize for obtaining the highest marks in her group in the Preliminary Examination, and at her graduation ceremony, was presented with another prize for her exemplary behaviour while she was living in the nurses' home.

During her training, Pauline established close friendships with Jane, a Pedi girl from Pietersburg, with whom she regularly went home to Jane's uncle's home in Molapo (Soweto) over free weekends; and Yvonne, the Zulu girl with whom she had first travelled to Johannesburg. She still maintains contact with these two friends by correspondence.

In 1967, when she turned twenty-one, Pauline's mother sent her, in addition to a gift, a cake and a silver key, and Pauline and her friends organised a party in the nurses' home, for all the students in her group. They bought cakes and cold drinks, and tea and sandwiches were organised through the nurses' home kitchen, for this party, at which the students displayed their ballroom dancing abilities[1]. The celebration of twenty-first birthdays is a relatively new phenomenon, and is not mentioned in informants' histories before the mid-nineteen-sixties.

After graduating as a general nurse in February 1969, Pauline completed midwifery and returned home to Durban, in response to her parents' wishes. Not being able to get a job at King Edward VIII Hospital, she applied to, and was accepted immediately by, McCord's. At the time of fieldwork, she was sharing a room in the nurses' home with a McCord's-trained staff nurse, who was a particular friend of one of the students in Pauline's midwifery training group, at Baragwanath. These two young staff nurses, one Zulu and one Xhosa, one trained at the premier provincial training school and the other at one of the best-known mission-type hospitals, had become great friends, and spent most of their leisure time in one another's company. Both had similar interests -- reading, ballroom dancing, going to the beach, listening to jazz and "soul" music, watching films (especially spy thrillers) and, when bored, doing handwork. Pauline also played tennis, in Johannesburg, and attended football matches as a concession to her boyfriend's interests. Fashion and dress were also important parts of Pauline's life: she was the first to introduce the new Afro wigs to the staff at McCord's, having acquired one on a weekend visit to Johannesburg, to attend a friend's wedding, in July 1970. She also

[1] A dancing instructor was employed by the nurses' home, and was constantly on hand. Most students spent much of their free time practising the steps he showed them.

attended -- but did not participate in -- beauty contests, "to have a good laugh at them parading around!"

Pauline herself is of medium height, and has a very good figure in western cultural terms. She is always exceptionally smartly dressed, whether she is in uniform, slacks, or evening dress. She uses make-up, and always wears a wig (of which she has three). Not unexpectedly, she has a boyfriend, who is eager to marry her, but she is in no hurry to get married. Her boyfriend, a Swazi, is in Johannesburg, working as a clerk. (The boyfriend she left in Durban on commencing her nursing training, was Bhaca, which seems to bear out her general feeling that nurses do not attach much importance to a man's tribal identity. She was amused, during her training, to notice how quickly rural Xhosa girls lost their scruples about going out with uncircumcised Zulu and Sutho men!)

Pauline's unwillingness to tie herself down in marriage, stems from two factors. She is keen to further her education in post-basic nursing courses, and perhaps even to go overseas; and she is worried about the instability of marriages among African nurses. She is also wary of potential mothers-in-law, for her boyfriend's mother is apparently keen that he should marry another girl with whom he has already broken up. Pauline is indignant about this on his behalf, for "she has already had her choice, when she chose her husband. She cannot expect to choose twice, for her son as well". Beneath her quiet exterior, Pauline has a decided will of her own, and she is in no hurry to acquire such a mother-in-law.

Before she left Baragwanath, Pauline asked one of the doctors to prescribe a particular brand of oral contraceptive for her, which she is

currently taking. She has no intention of bearing an illegitimate child, and also feels that she should know which brand suits her best, for future reference. If and when she does marry, she does not want more than two children, a sentiment which is shared by her room-mate.

The general pattern, as well as the details, of Pauline's background, differ from the general pattern exhibited in the histories of Elizabeth and Mary-Jane. These differences result from Pauline's age, her town upbringing, her marital status, and even changes in government policy, which have affected her educational background[1]. Of these three nurses, Pauline is the most sophisticated in terms of dress and interests (for example, in fashion and beauty contests). It is possible to regard Pauline (and others of her generation) as an example of the increasing sophistication of nurses: though unmarried, she uses modern contraceptives; she celebrated her twenty-first birthday by holding a party for her friends -- who were also nurses; her taste in literature is intellectual[2]; she is eager to travel to, and work in, other countries; and so on. She is not yet bound by the stabilising influences of marriage, home and family, as are Mary-Jane and Elizabeth.

Furthermore, it is apparent from the smaller numbers of kin appearing on her genealogy (see Case C: Pauline's Genealogy), that Pauline is not linked to non-elites to the same extent as are Elizabeth and Mary-Jane. Both of Pauline's parents are literate and are (or have been) employed in at least semi-skilled occupations. Their children will all be educated to a certain minimum level -- the Junior Certificate -- before they will be allowed to leave school. Perhaps Pauline's parents had become more aware of the value of

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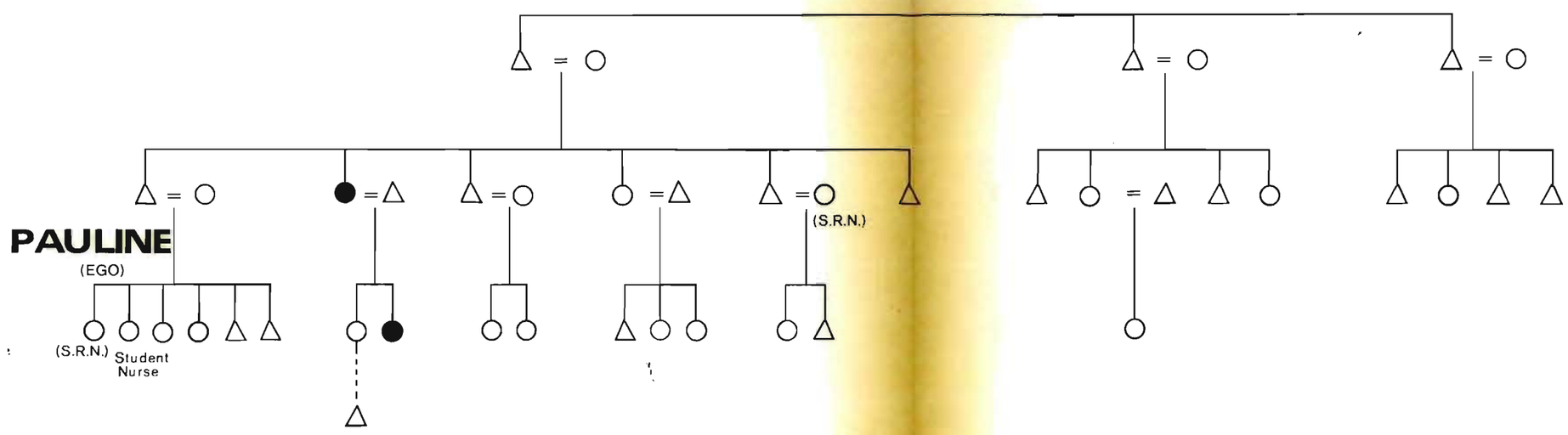
[1] Pauline's school career had only just begun when the provisions of the Bantu Education Act of 1953, were being implemented.

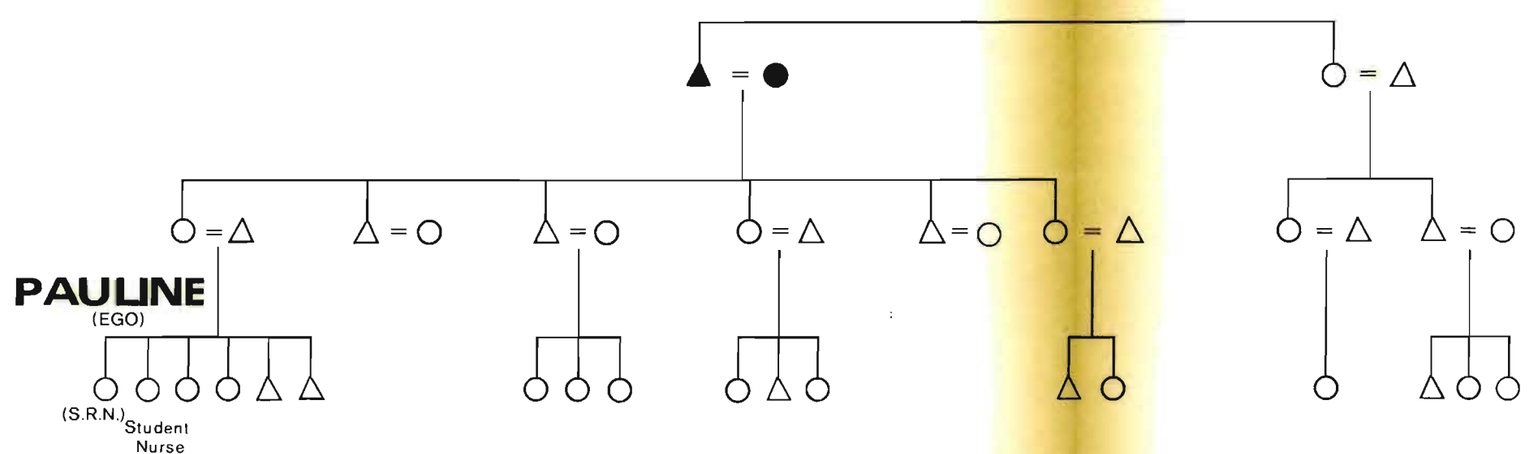
[2] At one time during the research period, she was reading a treatise on the American jury system, having borrowed the book from one of the (European) hospital doctors.



1 Patrilateral

CASE C. PAULINE'S GENEALOGY

2 Matrilateral



LEGEND:

- Male
- Female
- Deceased male
- Deceased female
- Illegitimacy

Western education to their children, as a result of their own relatively advanced education and/or their own semi-urban residence; or perhaps their occupations were sufficiently remunerative to make possible the education of all of their children.

One very important difference between Pauline, on the one hand, and Elizabeth and Mary-Jane on the other, lies in their respective educational and religious backgrounds. Both Elizabeth and Mary-Jane did their entire schooling at mission schools, and trained at hospitals in the missionary tradition, whereas Pauline was educated in a secular, government institution, and did her nursing training at a provincial hospital. Her contact with the missions has thus been minimal, yet her values and attitudes are much the same as those held by Mary-Jane and Elizabeth. In fact, Pauline is a Jehovah's Witness, as are the other members of her family. The entire family used to belong to the Anglican church, but when the African minister of the Greytown congregation was sued for adultery damages by the husband of one of his parishioners, Pauline's father removed his entire family from the Anglican church as a gesture of protest at the minister's misbehaviour. Several years later, Pauline's mother persuaded her husband to join the Jehovah's Witness sect, and again, the children (including Pauline, who was then nursing) were required to follow the lead of their father. However, Pauline does still attend Anglican services, occasionally, when she accompanies her room-mate to church. In general, however, the impression is that Pauline's commitment to her religion is less enthusiastic than that of either of the two older nurses, who have mission-oriented backgrounds. Pauline is not irreligious, but her elite status is, perhaps, tied less closely to her religious background.

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It may be seen, from the life histories of these three nurses, that the details of different nurses' lives may vary considerably. Nevertheless, the overall similarities in their attitudes, values and life style, are far more significant than the differences among them. Differences of religion, family background, age and marital status do give rise to differing interests and activities, to some extent, within the overall framework of elite identity. But while interests differ, attitudes and values are fairly constant, and I am reasonably confident that these common values are, at least partly, the result of a common socialisation process, for all nurses undergo similar, standardised training. In the following sections, then, it is necessary to examine this socialisation process in some detail.

CHAPTER NINE

ACCULTURATION AND THE POSITION OF A "MARGINAL ELITE".

Until now, I have tried to apply the elite concept, in a systematic manner, to the position of African nurses within their own African community. In so doing, for the most part I have deliberately ignored certain factors which complicate the nurses' position in the total South African society. These complicating factors, which I shall now examine, imply that my own use of the elite concept differs somewhat from the way in which this concept has been used by others, such as Lloyd and Nadel. Indeed, I believe that these factors cause African nurses (and other elite Africans in South Africa), to be categorised more accurately as "marginal elites". In order to justify my use of this apparently paradoxical term[1], I must first explain what I mean by "marginal" in this particular context.

The Concept of Sociological Marginality.

My use of the term "marginal" derives mainly from the work of Professor H. F. Dickie-Clark (1966), which deals with a Coloured community in Durban. In this work, Dickie-Clark stresses, firstly, the distinction between the so-called "marginal personality" (which is a constellation of personality traits arising from an individual's subjective definition of and reaction to his own particular situation), and the objective, sociological "marginal situation". The marginal personality is found within a marginal situation, but the marginal situation need not always give rise to such a psychological syndrome. It is possible, according to Dickie-Clark, to study

[1] Lloyd (1966:12-13) also refers to a marginal elite, in which category he includes those holders of traditional political office who have been educated in a western tradition, as well as the wealthy traders. As will become clear, my own use of the term "marginal elite" does not coincide with that of Lloyd.

a marginal situation without reference to the possible psychological effects this situation may have on certain individuals, and he emphasises (1966:3) that the marginal situation itself "does not consist of or imply any aberrant mental or emotional components". He is concerned, then, with the marginal situation solely from a sociological point of view. It is the sociological aspect of the marginal concept with which I am concerned in this chapter, too.

Dickie-Clark (1966:39) identifies "two broad categories" of matters regulated by a hierarchy, in which inconsistencies in hierarchical ranking may give rise to marginal situations:

> "...matters which belong to the cultural dimension of human interaction on the one hand, and, on the other, those which belong to the dimension of status and acceptance in a system of social relations."

In other words, he is drawing attention to the distinction[1] between culture and structure, with reference to marginal situations.

I will examine the cultural aspect first. Dickie-Clark notes that, when specific cultural attributes are (allegedly) linked to ascribed racial status by definition, any instance of substantial acculturation may result in an achieved status which is at variance with the ascribed racial role or identity. Thus, for South Africa, he notes that:

> "...the African who shares to any extent in the dominant culture is in a marginal situation." (Dickie-Clark, 1966:44).

This generalisation is perhaps somewhat sweeping, but his basic idea certainly seems to apply to African nurses, since nurses are subjected to a process of "acculturation", or "westernisation" (what I have previously referred to as "socialisation" into the medical ethos), which is certainly

[1] Noted previously: see pp. 28 - 29.

more intense and more prolonged than that of other professional groups (such as teachers), particularly among Africans in South Africa. The process of acculturation is also possibly more intense among nurses than the corresponding process is among other, more highly qualified professionals such as lawyers and doctors, because nurses are removed, physically, from the African community during their training, and their behaviour is very tightly controlled[1]. I have referred previously, in passing, to different aspects of this acculturation, or socialisation, process, but I feel that it is important to describe this process in rather more detail now, in order to emphasise the extent to which it occurs[2].

The Acculturation Process.

The student nurse is, during her training, subject to a particularly intensive socialisation process. Her life is hedged around with rules and regulations, and the life of the nurses' home is, in many respects, an extension and intensification of boarding school conditions, which most African students have experienced before beginning their nursing training. It is worth noting that the nurses' homes are usually (but not always) under the direct supervision of a senior member of the European nursing staff. Moreover, in Durban at least, because the Group Areas legislation has not yet been applied to African hospitals (which cannot easily be relocated and rebuilt in African townships), many nurses' homes attached to non-European

[1] At present, the University of Natal Medical School (which is the only medical school in South Africa exclusively for non-Europeans) provides hostel accommodation for the majority of its African students, male and female. But although they reside in these hostels for their entire, lengthy training, the control exercised over the medical students is slight, and is in no way comparable to the tight control characteristic of nurses' homes. The Medical School is also sited in an Indian/Coloured area, not a European area.

[2] The extent of this acculturation is, apparently, not accepted by certain European nurses (see the quotation from Searle, on p. 47 of this thesis).

hospitals, are located in otherwise European areas. For instance, the McCord's Nurses' Home is closely surrounded, on all sides, by European houses. Thus, even though the nurses do not necessarily interact to any greater extent with the Europeans who direct their training and control their lives while in the nurses' home, or with those who surround them residentially, the possiblity of such interaction is increased. Indeed, in such situations, Europeans may (and apparently do) become an overt reference group in terms of living standards and behaviour. Thus one of my informants (trained at McCord's) recalled, with pleasure, the comment of a friend (also trained at McCord's), made some years previously, about a photograph of herself: "Oh my! Who is that beautiful European lady?!" Such indentification with European standards (of dress, in this instance) is perhaps partly a reflection of the removal of African student nurses from African society, for a minimum period of three years.

Certainly, within the nurses' homes, and within the classrooms and wards of the hospitals, African student nurses (like their European counterparts), are constantly reminded that nurses are different from lay people in the community, and that their work is more demanding than most. In effect, the training period is the time during which the nurse is prevailed upon to accept, as morally binding, the ethics, ideals and practices of her profession -- including working overtime without pay, doing shift work and night duty, and undertaking the dirty tasks of nursing. To release the student back into the "normal" world after duty, would be to diminish her identification with hospital life, and would probably make her less willing to accept the heartaches and disadvantages peculiar to her profession: thus student nurses are required to live in nurses' homes, under the control of senior members of the nursing profession.

During this acculturation process, the African student nurse is, of course, living and working within a general system that has arisen in and is an integral part of western, industrial societies. As Kuper (1965:217) states:

> "Hospitals and clinics, the institutionalized milieu for professional employment, are part of a Western folk system of medicine. The scientific element, symbolized in microscope and laboratory, underlies the rationalization that health and life itself depend on such qualities as accuracy and hygiene."

The nurse studies intensively not only nursing procedures and techniques, but also anatomy and physiology, pharmacology and microbiology, medicine and surgery and all the other medical specialties. She is taught to recognise physiological signs and symptoms, and to relate these to one another in tentative diagnosis. She learns standard treatments for specific diseases, and also witnesses experimental changes in treatment techniques and medication. In addition to working within the germ theory framework, she is also taught how dietary deficiencies or excesses can cause or exacerbate particular diseases, and the importance of hygiene in connection with the spread of disease. All this and more she learns, seeing her increasing knowledge being put into daily application by medical and nursing staff. Most important of all, she witnesses the validity of the theory on which this practice is based, in the patients whose diseases are cured, whose chronic complaints are alleviated, whose dietary imbalances are corrected. From witnessing these successes, comes reinforcement of the new and initially alien concepts of western medical practice.

And the African nurse experiences not only the predominant success of western medicine: she also learns something of the variety of traditional

systems of belief regarding illness in different African societies. From the patients, Zulu and Xhosa, Sutho and Swazi, Pedi, Venda, Shangaan and Tswana, and from Ndebele, Shona, Tonga and others from beyond South Africa's borders, the nurse hears differing tales of disease causation and traditional treatments. Most such treatments have already failed, as is demonstrated by the patient presenting himself for "European" treatment. Indeed, some traditional beliefs are actively obstructive to the treatment ordered by the western-trained doctor, which the African nurse has learned is effective in that particular disease, and in which she believes herself.

As the nurse proceeds in her training, with such situations recurring innumerable times, her acceptance of the basis of western medicine becomes more and more firmly established, and she progresses from remembering what she has been told, parrot-fashion, to an internalised acceptance of this western system. The whole conceptual framework eventually comes to determine even her view of experiences prior to entering nursing, so that many an informant indulged in what might be termed "retrospective diagnosis" with respect to a deceased relative. "My father died in 19__. Looking back on it now, I think it must have been a coronary..." (or a stroke, or tuberculosis, or something else) was a type of comment made on several occasions by different nurses.

By the time the nurse has qualified and gained some experience, her knowledge of diagnosis and treatment is such that the newly-qualified intern has much to learn from her. Should she become a district nurse, she will, in fact, be fulfilling many of the functions of both doctor and chemist, as well as those of nurse, referring only those cases that are beyond her judgement, to a doctor.

PLATE VII.

On a darkened stage, holding lighted candles, newly-qualified registered nurses recite the Pledge of the International Council of Nurses. This photograph was taken at the 1970 Graduation Ceremony, King Edward VIII Hospital, Durban.

The very thorough acculturation process described above, is reflected in African nurses' values and life style (discussed previously), which are western-based. Of greater significance, however, than external indices such as homes and clothes, is the actual behaviour signalling these altered values. Thus in situations where one might expect, perhaps, a resort to practices based on traditional belief, among African nurses, such behaviour is conspicuous by its absence, even though it is not discounted as a theoretical possibility by nurses themselves, in response to social pressures from non-elite kin[1]. For instance, one informant described the "memorial service"[2] recently held by a teacher for her deceased husband, as being "pointless", for three reasons: "it is unnecessary expense"; "I do not believe that the dead person is in any position to be a bad omen"; and "there are other ways to honour a person's memory than by slaughtering and big parties". Finally she stated:

> "If I had my way, there would just be a small gathering of close relatives and good friends, to remember the departed soul and to pray for those left behind. But if my husband or brothers wanted me to partake in a memorial service, I would do so, not because I believe in the basic idea, but for the sake of peace, and to please them."

One might question this statement on the grounds that it deals with a hypothetical case -- what actually happens in practice? The following are some instances of actual behaviour. One informant was apparently unable to conceive. Did she then visit an inyanga? No: she herself underwent two diagnostic operations (dilatation and curettage, and a salpingogram[3]), and when no abnormality was discovered, she sent her husband to hospital for investigation. His semen analysis showed a low sperm count, and a chest X-ray revealed pulmonary tuberculosis. He was hospitalised for six months, and his wife conceived when his treatment was completed.

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[1] See Appendix IV.

[2] See Appendix V.

[3] A procedure in which air is used as a contrast medium for radiological examination of the Fallopian tubes, to test their patency.

Another informant and her husband had just completed alterations and additions to their home, raising the value of their original four-roomed township house from approximately R500 to over R2000. Did they sacrifice to their ancestors? No: they had sturdy burglar guards fitted and took out insurance to cover their furniture, and my informant told me, quite spontaneously, that others had suggested that they should beware witchcraft on the part of possibly envious neighbours, and that if they were not going to protect the house with _muti_ from an _inyanga_, then they really were running a risk by not even slaughtering a goat. She found this suggestion a rich joke.

A third informant and her husband had bought their own small car. She also laughed at the suggestion that they should throw a party to thank the ancestors, and specifically stated that their insurance policy took care of what the sacrifice theoretically should have, had they performed it. This particular informant regarded the idea of sacrifice as not only wasteful, but against Christian teaching as well, and she was the only one to add a religious element to her reasons for declining to follow traditional ways.

A fourth example concerns a nurse's infant, a few months old, who was crying and fretful for no apparent reason. Again spontaneously, she told me that, in terms of customary behaviour, she should take such a child to an _isangoma_, or an _inyanga_: instead, she had taken the child that morning to the hospital clinic, to confirm her own suspicions that the child was merely teething.

These examples show, then, that the nurses' expressed scepticism regarding traditional African beliefs, is supported by their behaviour. Nurses are aware of the expectations of African custom, and recognise these,

but they do not comply with them. Perhaps a measure of their distance from these expectations, is the fact that they can talk about them quite objectively, without a sense of "cultural shame" or even embarrassment, and quite openly. And further to this argument, they are even prepared to concede that, although they do not agree with these customs themselves, there are times when they might be in the position of participating in them, albeit peripherally, in order to satisfy the expectations of their kin.

It is my contention that the African nurse's whole attitude to African belief and custom, is shaped more by her training and role in the field of medical science, rather than by her prior missionary education or religious convictions. The acculturation process that I have described, provides the nurse with a radically new conceptual framework for identifying and treating illness, and this framework also gives her insight into the basis of western scientific thought. Her physical removal from the African community during the period of her training, thus becomes an ideological, or conceptual, separation as well. This "change from a traditional to a scientific outlook" (Horton, 1967:156) explains why the African nurse is sceptical and intolerant of traditional beliefs and practices regarding disease causation and healing in African societies. In the nurses' own words, such beliefs and practices are "unenlightened".

Indeed, Jarrett-Kerr (1960:32) notes that African nurses and doctors appear to be much more anxious than their European colleagues,

> "...to make an immediate and clean sweep of ancient tribal custom and to assert their recently acquired 'Western' knowledge".

This desire is undoubtedly related to the elites' attempts to establish new

values and alter the traditional culture to accord with their own value system. But it is more than an elite modernisation programme, for African doctors and nurses, particularly nurses, are in direct competition with persons filling traditional roles connected with healing, in African society. I am not thinking of financial competition in this context (although such financial competition does exist), but rather competition for status, influence and power. In much the same way as European doctors and nurses in White South African society frown upon chiropractors, homeopaths, and other "quacks" as a result of their competition in the field of healing, so do African doctors and nurses tend to reject the isangoma, inyanga and other roles traditionally concerned with the curing of illness.

If the argument is accepted, that the intensive period of socialisation (or acculturation) into the western medical ethos, effects the radical change in values and behaviour among African nurses, that I have tried to describe in this thesis, then the question must arise: what about the exceptions? Isolated cases are widely reputed to exist, in the African community, of a nurse, fully trained and qualified, becoming an isangoma. Apart from pleading that the exception proves the rule, how are these cases to be explained?

My informants themselves, for the most part, explained such cases in terms of mental disturbance. (In view of the multiple conflicting expectations of the African nurse, it would be interesting to ascertain what the actual incidence of mental disturbance is among them.) Another type of explanation was given by one, rather cynical nurse, who quoted me a case she had heard of, concerning a nurse who had become an isangoma and later returned to nursing. My informant explained this turn-coat behaviour in terms

of unsatisfactory financial returns, in which nursing proved to be less unsatisfactory! A third type of explanation was given by one very religious nurse, who suggested that it is the person who is poised precariously between Christianity and pagan beliefs, who is most likely to become an isangoma. My own suggestion is that, in cases where the socialisation or acculturation process has been less than complete -- for example, among nurses who start their training at a later age, and who are less flexible and receptive to the new framework -- the possibility that the individual may yield to traditional expectations, is increased. I should add that I have no objective support for any of these hypotheses, since I have not met, personally, any nurse who has become an isangoma. In any case, it would seem that the number of nurses who are reputed to have become isangoma's, is extremely small, since only two cases were actually known to my informants. It would seem that, in general, the process of socialisation into the western medical ethos is sufficiently thorough to remove the possibility that the African nurse might adopt a traditional healing role.

It would also appear that the acculturation process, with its resulting "scientific" attitude, is what makes African nurses (and doctors) clearly distinguishable within the category of elites, setting the medical and nursing professions apart from other elite occupations. The "scientific" attitude also differentiates the nurse from African women in general, and is probably responsible for much of her independent, even "feminist", attitude to "uneducated" African men.

Thus it may be seen that the nursing training, with its induction into the medical (and professional) ethos of modern, industrial societies, results in precisely that adoption of the culture of the dominant white group in South Africa, which Dickie-Clark identifies as giving rise to one type of

marginal situation. Such a marginal situation arises because this acculturation process produces inconsistencies between the nurses' ascribed (racial) and achieved (cultural) status. As a result of the acculturation process, nurses are culturally distinct from the remainder of African society (particularly non-elites). At the same time, certain structural consequences of this acculturation, in South Africa, make nurses (and other African elites) marginal to the dominant European group. Thus African elites, including nurses, are marginal within the total South African social structure.

In fact, although he recognises that cultural factors may give rise to marginal situations, Dickie-Clark (1966:185) gives precedence to the structural aspects in his definition of marginality:

> "...the marginal situation is a special case of hierarchical situations. What makes an hierarchical situation marginal in character, is any inconsistency in the ranking of the individual or collectivity in any matter regulated by the hierarchical structure...such inconsistency is the essence of the marginal situation, or what might be called sociological marginality."

The structural consequences of the acculturation process which has produced (and is producing) the marginal situation in which African nurses, in particular, find themselves, should become clear when a comparison is drawn between the role that a nurse should, theoretically, fulfil, and the role that the African nurse in South Africa is actually permitted to assume.

The Roles of "African Nurse".

The occupational role of "nurse" is that of a health specialist, whose knowledge and skills are important in the processes of maintaining and

restoring health. This role necessarily contains a marked element of authority. The sick person assumes the role of "patient" or "invalid" on condition that he submits himself to the care of recognised health specialists in order to regain his former state of health, and thus re-assume his normal roles in society. In terms of authority, then, the role of patient is subordinate to the role of nurse. Indeed, nurses are well aware of the authority they have over patients. Kuper (1965:228) quotes one African nurse as saying:

> "'Perhaps the men behave like this toward us because they are jealous, knowing that we won't marry them. <u>As patients they have to listen to us</u>.'" (My emphasis.)

Similarly, the success of the whole complex process of healing (or at least alleviating the condition of) the sick, demands that some nurses also have authority over other nurses, who are junior to them in terms of professional status. Thus the role of matron carries authority over all other nursing roles -- sister, staff nurse, student, auxiliary, and so on. At the very lowest rungs of the professional hierarchy, the ward attendant has very minimal, controlled authority over the patient, and none at all over any other grade of nursing personnel.

However, in societies such as South Africa, as Banton (1965 a:175) indicates,

> "...being White or Indian or Bantu or Negro is a role, and most other roles a man or woman assumes have to be congruent with his or her basic racial role".

Thus the African nurse enacts the role of "African", as well as the role of "nurse", and in South Africa, the ranking of authority which results from the definition of nursing roles, is at variance with the hierarchy, or system of

stratification, based on the assignment of roles in terms of racial identity.

Thus, according to the professional definition of nursing roles, the trained nurse, under the supervision of the doctor, should control the treatment of the patient, who is normally expected to follow the nurse's instructions. But in the South African situation, an African nurse (no matter what her rank in the professional hierarchy) may not treat a White patient, except in an emergency, when there is no alternative. (And in such circumstances, a report must be submitted to the South African Nursing Council, giving details of the situation.) This ruling means that, in any department of a non-European hospital where a European may have to attend for treatment on an official basis (as happens, for instance, in the Casualty and Outpatients Department at Clairwood Hospital), there must be a European sister in charge of that department. Similarly, according to the professional hierarchy, the trained, registered nurse has authority over the student, but, in South Africa, no African registered nurse may be placed in a position of authority over a White student. And again, the matron ordinarily controls all other ranks of nursing personnel, but African matrons (of whom there are by now a fair number) may not control wards that are run by White sisters: White sisters in non-European hospitals must be subject to the authority of White matrons. In all of these situations, then, it is quite clear that the basic racial role of "African" overrides the general occupational role of "nurse", and produces inconsistencies in the ranking of the African nurse, which Dickie-Clark identifies as being the core of marginal situations.

In this situation, whereby the basic racial role alters expectations of her behaviour on the part of the individual African nurse herself, as well as the expectations of other persons involved in the situation, one might perhaps expect to find altered role behaviour resulting from these altered

expectations. Thus it would not be surprising if the African nurse were to fulfil her professional role differently from the European nurse. To some extent, this idea involves Merton's (1957:423) notion of the self-fulfilling prophecy, which states that, in a given situation, because the others expect a certain type of response from an individual, they get it; and were this expectation not held, the (initially false) premise would not be rendered true in behaviour. Thus the complaints from some White nurses and some doctors of all races, that African nurses are irresponsible, incapable, and so on[1], may well be the result of some African nurses reacting in accordance with these expectations of the African nurse, who, because of her racial role, is not expected to be the equal of her European counterpart -- indeed, is expected to be different from the European nurse -- despite her identical professional qualifications.

I have shown that the basic racial role of "African" overrides the African nurse's professional status, in situations involving inter-racial contact, in the South African colour-caste hierarchy. A similar situation could be outlined for other African professionals as well. It would seem that, as Dickie-Clark has indicated with reference to Coloured people in South Africa, the composite (colour-caste) hierarchy regulates many more aspects of, for example, African nurses' lives, than does the restricted hierarchy of the profession of which they are members. Indeed, the history of legislation affecting the nursing profession in South Africa[2], provides

[1] I must hasten to add that by no means all European nurses or all doctors hold this opinion: many explicitly reject it. However, a similar conclusion to my own on this issue, is reached by White (1966), who attributes differential stereotypes of African and European nurses, to racial prejudice on the part of those holding the stereotypes. My own research impressions suggest that these differences would appear to be largely putative, and that individuals of both racial categories may be located on a single continuum of abilities and skills, without racial clustering. I did not, however, attempt to quantify this impression.

[2] See chapter three.

graphic illustration of the processes which decreased the control of the professional nursing hierarchy over its members, while increasing the control of the composite hierarchy in this respect. The 1957 Nursing Act (As Amended) was the means by which this transfer of control, from the restricted (professional) hierarchy to the composite (racial) hierarchy, was effected. One could summarise this Act by noting that it involved a reversal of the legal integration of European, Indian, Coloured and African nurses in the nursing profession, which integration had previously existed in terms of the 1944 Nursing Act.

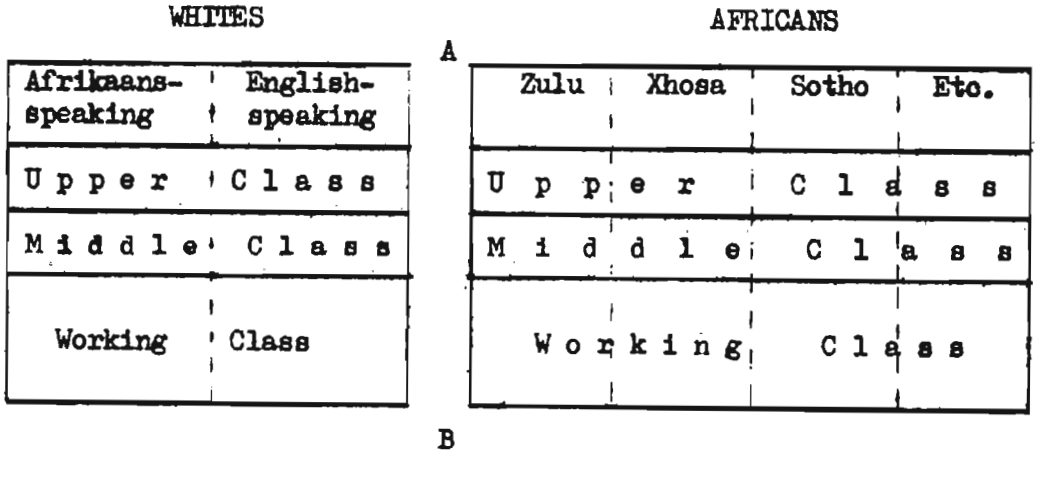
Opportunities for inconsistencies to arise in the ranking of groups or individuals for different purposes are, perhaps, increased in composite hierarchies based on ascribed characteristics such as racial identity. Such inconsistencies are, of course, based on the well-worn distinction between ascribed and achieved statuses. For when the ascribed position is defined as basic, achieved status must invariably and inevitably clash with it. It is in this context that one must view the conflicting elements in the roles of the African nurse in South Africa.

One of the reasons why inconsistencies in ranking should arise and continue to exist, is that certain inconsistencies in the position of members of subordinate strata, may actually work to the benefit of the dominant group and may, therefore, be encouraged (Dickie-Clark, 1966:37). In applying this idea to the position of African nurses, it is evident that, in terms of the policy of separate development, it is necessary to train African nurses to staff African hospitals. But, as I have shown in the previous pages, identical professional training and qualifications do not lead to full acceptance of African nurses into the system of social relations of the dominant White group in South Africa, because of their differing racial

identity. Thus African nurses are placed in a marginal situation, in structural terms, relative to the dominant stratum of South African society, while they are culturally distinct from the majority of members of their own (subordinate) racial stratum.

The Marginal Situation and Separate Development Policy.

In terms of the official policy of separate development, one should perhaps anticipate the eventual division of the nursing profession into three (or four, or perhaps eleven) sections, each distinct from the others, each with its own controlling authority. The differing "national" segments of the total society are to be compartmentalised, in the ideology of separate development, and one would expect professional bodies to be compartmentalised in similar fashion. The "multi-national" situation (in official South African terminology) has been represented diagrammatically by Banton (1967:178, figure 11: The colour line as it is envisaged in separate development), as follows:



In separate development, then, the colour bar is to swing from a horizontal position, beyond the tilted position described by Warner (Banton, 1967:144), to a vertical position. In this situation, the system of social relations within each segment is conceptualised as distinct from that of each of the other segments. Thus overall equality in the total system is defined away at

the theoretical level. Should this system come into operation, then, it seems unlikely that there would be a carry-over of the professional status of Africans into the White sector.

Jarrett-Kerr (1960:80) states that the possible division of the nursing profession was considered at the time of the 1957 Nursing Act, and that such a division (on a racial, not "national" basis, at that time) was regarded, by certain proponents of the policy of separate development, as an honest and equitable solution. But while such fragmentation of the nursing profession would possibly have removed some of the inconsistencies in the position of non-European nurses, it was not acceptable to European nurses, because of the position of the South African Nursing Association within the International Council of Nurses[1]. The South African Nursing Association had to represent the interests of all nurses in South Africa, regardless of racial identity, and the profession could not be divided on the basis of differing racial characteristics. Thus the compartmentalisation of differing segments of the nursing profession, on the basis of "nationality", has not been achieved, and it seems unlikely that such division will be achieved in the future. As I have shown in the section on the roles of the African nurse, South African society remains, at present, stratified on a horizontal basis, and the colour-caste hierarchy of the plural society is still in operation, as far as the position of African professionals is concerned. The ascribed racial role is of greater significance, in situations involving inter-racial contact, than the achieved professional role.

Thus one finds, in South Africa, the paradox of a "marginal elite", among African professionals. Nurses, and other professionally qualified Africans, are elite within one sector of the society, but they are not

[1] See chapter three, pp. 48 - 50.

recognised as having elite status in the total society. Their marginal position arises from the inconsistencies between their position as professionally-trained and qualified nurses, and the status that is assigned to them, in South Africa, on the basis of their racial identity. The marginal situation in which African nurses find themselves in South Africa, is summed up very neatly in the words of a Johannesburg delegate to the 1970 Congress:

> "We may be separated by race, but the work pulls us together."

CHAPTER TEN

CONCLUSION

In chapter two, I examined some of the arguments in favour of the use of the elite concept in discussing social stratification in Africa today, and thereafter, I attempted to present, as systematically as possible, evidence to support the contention that African registered nurses in South Africa belong to the elite stratum. In discussing why the concept of elites is particularly valuable, I gave precedence to the factor of the cultural distinctiveness of elites, as one important reason why the notion of social classes is inapplicable, at present, to African societies. There are, of course, other reasons for favouring the use of the elite concept in preference to social class.

One of these reasons concerns the dangers of attempting to apply, to African societies, stratification concepts which have been developed for western societies. Lloyd (1966:49), for instance, warns that such attempts may well result in "misleading usage of the terms or in falsification of our data". Lloyd himself rejects class analysis in favour of using the elite concept, because

> "... a social class can exist only in a system of classes. There can be no upper class without a lower class...if the African elite forms an upper class, where are the lower classes?" (Lloyd, 1966:60)

Plotnicov, however, opposes the logic of Lloyd's view with the logic of his own. He asks:

> "Is it possible that a social group -- in this case the modern African elite -- can possess all the characteristics of a

> social class and still not be considered a class because there are no other classes in the society with which it can be in political and economic competition?" (Plotnicov, 1970:270)

In part, this divergence in views would appear to be the result of differing definitions of class. Plotnicov's notion of class would appear to be Marxist in essence, for he is concerned with the competitive nature of classes and class conflict. Lloyd, on the other hand, inclines more towards Warner's idea of classes as status groups, and he rejects the Marxist concept of class completely, as far as its applicability to modern Africa is concerned.

> "Classes in the classic Marxist sense of property-owning and non-owning groups exist neither in traditional nor modern African society." (Lloyd, 1966:56)

Having rejected the Marxist idea of classes in Africa, Lloyd proceeds to reject non-Marxist classes as well, not only because of the lack of an hierarchical class system, but for the following reasons as well. Firstly, there is the lack of internal knowledge of class divisions in African societies. Social division and categorisation, as seen from within these societies, tend to run along ethnic, descent and age lines, rather than along the lines of horizontal stratification on the basis of affluence, occupation, status and so on. And secondly, he notes that, in the interests of promoting national unity in the face of tribal divisions, in newly-independent African states, a political ideology of classlessness is found, propounded by elites (Lloyd, 1966:59). Lloyd therefore opts firmly for the use of the elite concept in situations of rapid social change and mobility, such as are found in Africa today.

Most writers on the subject of social stratification in modern Africa,

would probably agree with Lloyd that a system of social classes does not exist at present. Even Tuden and Plotnicov (1970:21) concede that:

> "... until further crystallisation occurs, we regard social classes as more potential than actual, more analytical than concrete categories."

But they do not agree with Lloyd's view that a single class cannot exist outside a system of classes. Tuden and Plotnicov (1970:21) regard the modern elite as "an almost fully developed social class"[1]. In so doing, they are prepared to regard the undifferentiated masses as a "residual category" (Plotnicov, 1970:300), forming the base of the stratification pyramid. I would suggest that such an analysis stretches the concept of social classes beyond its limits of usefulness. If one is going to define the lower social categories negatively, surely it is less misleading to make the negative definition explicit (as in the term "non-elites" for instance), than to talk about "residual categories" which include upwards of seventy-five per cent of the total population.

It would seem, then, that there are several reasons why the elite concept is preferable to that of social class when discussing social stratification in Africa at present. The most important of these reasons are the absence of a class system, lack of knowledge regarding class distinctions on the part of the people themselves, and the cultural differences between elites and non-elites. However, it is assumed by most authors that the elite concept will become less important in the future, as increasing economic development and modernisation give rise to a system of classes. However,

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[1] Cf. Kuper (1965:130), who states that:

> "If a society is structured on class lines, then presumably all sections are located within classes. When applied however to a society in transition, or to a plural society, there may be some value in conceiving an interim situation in which a stratum emerges from an undifferentiated urban mass and becomes conscious of itself as a class by the criteria of the dominant society."

Tuden and Plotnicov (1970:18) sound a note of caution on the possible development of a full class system in the future.

> "We must recognise that the association of social class with industrialization is a concept that derives from limited empirical instances, and that its nature is that of a hypothesis which remains to be tested. The conditions in Africa provide only part of the test."

Thus it would appear that a good deal more research and empirical data on the subject of stratification, are necessary, before stratification concepts developed with reference to western societies may be applied to African societies. As Ardener (1967:65) points out:

> "... discussions of whether there are, or not, 'social classes' in one country or another, or whether 'elites' are, or are not, turning into 'social classes' do not rest upon a firm analytical basis."

Thus there are differences of opinion between Lloyd, Nadel and others favouring the elite concept, on the one hand, and Ardener, Tuden and Plotnicov and perhaps Kuper, on the other, who regard the concept of social class as the more acceptable alternative, both now and in the future. Those favouring class analysis consider that the elite concept has outlived its usefulness. In my own study, however, I have found the elite concept of great value in detailing the position of western-educated, professionally qualified African nurses. In the context of this particular study, the elite concept has permitted the identification of particular characteristics of this specific occupational group -- characteristics which would probably have passed unremarked in an analysis of their position as members of a given social class. As shown earlier, for instance, the concept of elite status and values sheds light on the relationships of nurses to other nurses, to teachers, to their husbands, kin, servants and neighbours. It is doubtful whether class analysis

could have explained these relationships as well.

In showing why African nurses in South Africa may and should be regarded as elites, however, it should be noted that although I have analysed my data in relation to the elite framework, the research itself was not undertaken in an attempt to test the hypothesis that nurses may be regarded as elites. However, it may be seen that, in terms of the five main criteria by which elites may be identified (according to Nadel's framework), African registered nurses do have elite status.

In the first place, these nurses form a collectivity, ten thousand-strong, within which they identify with one another. This ideological corporateness may be translated into active social alignment in their friendships with other nurses, and in their membership of certain voluntary associations, including churches.

Secondly, the nurses' identity as professionally qualified Africans gives them high social status, and this high status is reflected in the reported prestige rankings of occupations. In South Africa, the nurses' status is perhaps somewhat higher than is the status of nurses in other African countries, because of the difficulty African men experience in gaining such qualifications. Indeed, in South Africa, the status differential between professional nurses and their non-professional husbands, is one source of tension in marital relationships, as the nurses themselves are well aware. The nurses' high status is also reflected in the associations to which they do belong (their professional association, orthodox churches, and particularly the Catholic Nurses' Guild. And associated with their high status in the general African community, is the fact that nurses tend to hold aloof from membership of

most voluntary associations[1].

The third main criterion of elite status -- that is, restricted admission to the elite stratum -- is also found among nurses. The nursing profession itself restricts the admission of new personnel, on the basis of professional training and qualifications. However, the restrictive influence of education is also apparent, since relatively few Africans have been educated to a level that will enable them to gain such professional qualifications. And there is a third, perhaps more subtle, restriction on admission to the nursing profession in particular, for qualified African female nurses outnumber qualified African male nurses in the ratio of approximately 100:1. Thus it may be assumed that admission to the nursing profession is also restricted on the basis of sex. But although admission to this section of the elite stratum is restricted, in the past two decades, the expansion of the nursing profession among Africans in South Africa, has been marked.

In terms of the fourth criterion of elite status, it is quite obvious that nursing qualifications and identity are achieved, not ascribed. But although the status of a "professional somebody" is achieved, this identity conflicts with the elites' ascribed racial status in South Africa.

Finally, in terms of Nadel's major criterion of "generalised superiority" in the social sphere, I have shown that African nurses are imitable. They are innovators and standard-setters, for at least part of the African population, in their life style, which includes living standards, dress, leisure activities

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[1] Pauw (1963:179) notes that:

> "Without doubt the highest status is generally accorded to persons like doctors, teachers, trained ministers and nurses...there is some indication of a growing tendency among women of this level to keep somewhat aloof by not mixing on the personal level and by forming a more exclusive type of association."

and so on, and in their values. Nurses not only set an example to non-elites, they actively promote their own imitability through their personal relationships with non-elites -- kin, servants, and even neighbours.

But despite their elite status in the Black sector of South African society, I have shown that African nurses are, and will remain (at least in the foreseeable future) marginal to the system of relations involving the dominant White group. Thus their elite status is not unqualified. Moreover, the fact that these nurses are women, means that their status as elites is, perhaps, a little anomalous. As Owen (1968:72) points out with reference to western societies, few women have full-time occupations in their own right and in general, a woman's status is, to a large extent, reflected from that of her husband or father. Brandel-Syrier (1971) apparently accepts this idea, for she states (1971:xxv) that her study was concerned with "...sixty African male individuals who...constituted the entire social elite of a Bantu township on the Reef..." Thus, at the outset, she has eliminated the possibility that any women had such status. Yet later (1971:84), she states:

> "But a wife was not only an important expression of a man's status, she could also be an important status raiser. It was generally agreed in Reeftown that 'a wife can pull her husband up'. This applied particularly to those cases in which the man's education or occupation was not quite sufficient to give him upper-class status. Hence the large number of businessmen who married nurses."

Given this information, one can only ask whether it is the man or his professionally qualified wife who actually has elite status. Perhaps it would not be too far wrong to suggest that, where a non-professional man marries a professional woman, he gains the status she loses by such a marriage, and at least part of her high status comes to be regarded as his. The above quotation from Brandel-Syrier would certainly appear to lend some support to my contention that the status of nurses is considerably higher than that

of non-professional African men, despite the fact that nurses are women.

Even though my application of the elite concept to African nurses is subject to some qualifications, and even though the position of any African elite in South Africa must differ from that of elites elsewhere in Africa, it seems to me that there are many marked similarities in the life style and values of African nurses in this country and those reported to be characteristic of elites elsewhere on the continent. Indeed, some of the nurses' attitudes (for instance, those regarding contraception and family limitation) could be argued to be more elite than the corresponding attitudes of, say, West African elites, as these have been described in the literature on this subject.

Yet, as with all elites, the continuation of their present status must be uncertain. I have already shown that the nurses' elite status has been acquired largely by default, in that there have been relatively few opportunities for African men to acquire the professional qualifications which (at least in part) confer elite status. If, in the future, the opportunities for male professionals are expanded, and the normal full range of occupations emerges in each "national group" in South Africa (in accordance with separate development ideals), one would expect the prestige currently associated with the nursing profession, to decline. This long-term future possibility is, of course, associated not only with the viability of the policy of separate development, but also with economic development and the emergence of a class structure in African society (as envisaged by Plotnicov, 1970). Should this hypothetical situation come to pass, one would expect that the prestige of nursing among Africans, would decline to a level similar to that which it has among Europeans in South Africa.

Already, one could predict that, unless the salary scales for African nurses are raised and subsequently maintained at a relatively high level, the status of nurses will suffer. For one of the reasons why nursing has been such a prestigious occupation among Africans, in the past, has been that nursing salaries have been high by African standards. But the number of non-professional, white-collar jobs for Africans in South Africa, is increasing, and these occupations are, at present, more remunerative than nursing[1]. The maintenance of elite living standards requires, of course, an income substantially higher than the average.

While income is important in achieving and maintaining elite status, it is perhaps less important than occupational skills and participation in a complex, modern occupational structure. Thus as a wider range of skilled, semi-professional and professional occupations becomes available to Africans in South Africa, the special position of the nursing (and teaching) profession(s) may be expected to alter. Nurses and teachers have, in the past, enjoyed exceptionally high status, compared with the status of their counterparts in other countries, precisely because of the lack of other employment opportunities. With increasing occupational specialisation, however, one may perhaps expect to find a growing awareness of class identity and class distinctions, of a more complex order than the educated/uneducated distinction which exists at present. And in such a class structure, one may expect to find nurses occupying a lower social position than they do at present. With the development of a class structure, then, the status of African nurses as elites in South Africa, may wane and finally disappear.

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[1] At present, the starting notch on Natal Provincial scales for African registered nurses, is R840 p.a. (R70 p.m.). The starting salary for qualified African teachers is R780 p.a. (R65 p.m.). The Sunday Tribune (29 August 1971) gives the following salary scales for African posts with the Durban City Council: clerk grade II, R146-R152 p.m.; truck driver, R90-R105 p.m.; health inspector, R119-R224 p.m.; health visitor, R112-R147 p.m.; traffic constable, R65 p.m. fixed. The highest salary an African university professor may be paid at present is R5 520 p.a. (R460 p.m.).

APPENDIX I

QUESTIONNAIRE[1]

If any question does not apply to you, please put N/A (Not Applicable) next to it.

1. In which year were you born? . . . . . .

2. What was the highest standard that you passed at school? . . . . . .

3. What church do you belong to? . . . . . .

4. What is your marital status? (Please indicate the correct category by X.)
   single . . . . . .
   married . . . . . .
   separated . . . . . .
   divorced . . . . . .
   widowed . . . . . .
   (remarried) . . . . . .

5. How much lobola was given when you were married? (Approximately) . . . . . .

6. In which year did you get married? . . . . . .

7. How many children do you have? . . . . . .

8. What was the highest standard that your husband passed at school? . . . . . .

9. What is your husband's work? . . . . . .

10. Have you ever lived apart from your husband since getting married (e.g. in a Nurses' Home)? . . . . . .
    If so, for how long did you live apart? . . . . . .

11. Please list <u>all</u> of the hospitals, clinics, etc., at which you have worked, including your training hospital(s). . . . . .

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[1] This questionnaire was distributed to 930 African registered nurses, of whom 226 returned completed schedules. The accompanying letter explained the purpose of the research, and emphasised that identification was not required, and that information would be kept confidential.

APPENDIX II

COMPARATIVE FIGURES FOR CERTAIN OCCUPATIONAL CATEGORIES.

The following figures were derived from the 1960 Census, and have been abstracted from 1970 South African Statistics, compiled by the Department of Statistics, Pretoria, and published by the Government of the Republic of South Africa.

AFRICAN MALES	OCCUPATIONAL CATEGORY	AFRICAN FEMALES
23 000	A. Total professional, technical & related.	25 487
2	Architect	-
19	Engineer	1
11	Surveyor	1
1	Chemist/Physicist	-
23	Vetenarian/Biologist	3
83	Medical Practitioner/ Dentist	24
1 127	Nurse/Midwife/Nursing Aid	12 786
87	Medical Auxiliary	16
2 852	Other medical Services	296
11 871	Professor, Teacher, etc.	11 585
35	Jurist	-
242	Draughtsman/Technician	13
11	Chartered Accountant	-
6 634	Other professional	759
5 458	B. Administrative, Executive & Managerial: total.	285
18 276	C. Clerical: total.	1 000
25 522	D. Salesworker: total.	3 372

Unfortunately, figures from the 1970 Census (for occupational categories) are not yet available. However, since 1960, the number of African registered nurses alone has doubled, and attention has been paid to producing more female than male teachers. One could expect, then, that the 1970 Census figures will probably show that the gap between male and female African professional workers, is widening in favour of African women.

APPENDIX III

PROCEDURE ADOPTED FOR THE OGWINI BRANCH.

A. NAME AND OBJECTS.

1. That the Branch shall be called Ogwini Branch of the South African Nursing Association.

2. That the objects of the Branch shall be

   (a) To raise the status, maintain the integrity, and promote the interest, and open up opportunities for study and service of the Nursing and midwifery professions.

   (b) To consider and deal with any matter affecting Nurses or Midwives or student nurses or pupil midwives.

B. COMPOSITION.

3. That all trained Nursing and Midwifery persons as well as Nursing and Midwifery students, and enrolled Auxiliary Nurses of African descent falling within the region of the Ogwini Branch of the S. A. Nursing Association, shall automatically become members with due subscriptions paid.

C. CONTROL.

4. The Headquarters of the Branch shall be King Edward VIII Hospital.

5. That the Headquarters of the Branch shall have meetings held not less than four (4) times a year i.e. every three months.

6. That the meetings during other months will rotate in order to arouse interest in the various institutions within the region.

7. The affairs of the Branch shall be controlled by an Executive Committee consisting of eleven members, four of whom shall be office bearers -- that is:-

   (a) (i) Chairman
   (ii) Vice-Chairman
   (iii) Secretary
   (iv) Assistant Secretary.

   (b) Members shall hold office not more than three years in succession, but one shall be entitled to belong to the Executive Committee as long as he or she is elected as such.

   (c) Any member of the Executive or other office bearers shall be eligible for re-election.

   Elections for office bearers and for Executive Committee shall be held once every year in April.

CLASSIFICATION OF MEMBERSHIP.

8. Members shall be divided into the following classes:-

(a) Full members: These shall be state registered Nurses and Midwives.

(b) Junior Members: These shall be State Student Nurses.

(c) Associate Members: These shall be Enrolled Auxiliary Nurses.

MEETINGS.

9. PROCEDURE: Before each meeting the Agenda shall be circulated to the Local Representative at most, 14 days prior to the meeting.

10. Accurate minutes of meetings shall be kept by the Secretary and shall be available to members of the Branch on request.

11. The Branch shall further decide upon its rules or procedures subject to the standing rules and orders, appended hereto.

12. (a) The Executive Committee shall consist of eleven members.
(b) The Quoram (sic) of the Executive Committee shall consist of five Executive members.

13. Besides the quarterly Executive meetings held at the Headquarters seven days before the quarterly general meeting, there shall be other Executive meetings in between.

14. Besides deciding its own rules of procedure, the Executive shall deal with urgent matters and shall also carry the resolutions of S. A. Nursing Association in consultation with the Branch.

15. Accurate minutes of the Executive shall be kept by the Secretary. Where a centre is not represented on the Executive, it shall be invited to send an observer to all Executive meetings.

16. PROCEDURE: Proposals by members of the Executive, when the Executive is not meeting, shall be forwarded to the Secretary, who will lay them before all members of the Executive by post.

17. Each institution or establishment shall form its own sub-committee to advise the people of the proceedings of the previous meeting. Such Sub-Committee shall be responsible for collecting dues and subscriptions in their respective institution, and establishments and shall forward such collections to the forth coming meeting.

18. Non attendance by an Executive or Office Bearers at three consecutive Executive Meetings without prior notification of the Secretary shall mean automatic ceasation (sic) of such member as an executive member. His or her place shall be filled by co-option by the Executive until the following General elections.

19. Elections for Office Bearers and for Executive Committee shall be held once every year in April.

20. VOTING POWERS.

(a) That only full members shall vote at all general meetings.

(b) Only the Chairman shall have the right to cast a vote (sic).

21. There shall be subscriptions to the Branch of 30 cents half yearly or 60 cents yearly.

22. The Finances of the Branch shall be kept in a Building Society Account. Withdrawals shall be signed by three members: the Chairman, the Secretary and the member of the Committee appointed by the Committee.

23. Amendment of Procedure Adopted for the Ogwini Branch.

(a) Any amendment or Additions to this Procedure shall be passed and become effective if carried by a 2/3rd majority vote of members at an Annual General Meeting.

(b) All proposed Amendments shall be published three weeks prior to the Annual General Meeting at which they are to be considered.

24. Ceasation (sic) of Membership.

Any member may be deprived of his/her membership, if he/she is deemed by a 2/3rd majority of the delegates at a meeting, to have acted in a manner detrimental to the interest of the Branch. Such person must receive adequate opportunity of presenting him/herself before the meeting.

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The constitution of the Ogwini Branch has been reproduced here without alteration or correction.

APPENDIX IV

A FICTIONAL EXAMPLE OF CONFLICT BETWEEN ELITE AND TRADITIONAL VALUES

One of my informants wrote a short story, which appeared in serial form over a number of weeks in 1970, in the Catholic weekly publication umAfrika. This story concerns a young rural Christian man, who goes to town to work as a clerk. He meets and marries a staff nurse, and insists that his wife stay with his parents in the country, against her wishes.

Although they wish to have children, the wife does not conceive. She consults a doctor and undergoes thorough medical examination, and the doctor states that there is no physical reason why she should not conceive. Her parents-in-law, with whom she is living, then insist that she visit an inyanga. At first she is horrified, but eventually she accedes to their demands and visits the inyanga, with her mother-in-law.

The husband learns about this visit to the inyanga when he comes home for a weekend visit, and, being a good Christian, he is so angry that he refuses to allow his wife to stay with his parents any longer. They return to town together, and establish their own home. Psychologically at ease for the first time in her marriage, and removed from the tensions of living with affines, the wife conceives. Here the story ends.

If one assumes that one of the ways in which norms and values percolate through a community, is by means of news and other mass media of communication, this simple story is highly significant, for it is putting forward not only new behaviour patterns, but reasons for these. It is perhaps another instance

of the ways in which nurses may promote their own imitability, this time by means of the written word rather than through interpersonal relationships. It also illustrates the conflict of values between nurses and their husbands, in the initial instance, and their senior affines particularly. It also validates the breach of relations with the senior generation, for once they are settled in their own home, as the nurse initially wanted, they are rewarded with children. The choice of a nurse as the heroine who is proved right is also significant, though perhaps inevitable since the story was written by a nurse.

APPENDIX V.

THE MEMORIAL SERVICE: A SYNCRETIC RITE.

In May 1969, two newspaper reporters were killed in a motor accident *en route* to the funeral of Cyprian, Paramount Chief of the Zulus, at Nongoma. The car in which they were travelling left the road and plunged down a cliff not far from Nongoma. One of these reporters, Fred M____, who had been on the staff of *Ilanga lase Natal*, was buried on the mission at Mariannhill. He was approximately thirty-six years of age when he died, and his widow, an infant school teacher, was responsible for the events described below[1].

Fred M____ was buried at Mariannhill some five or six days after his death. The Catholic funeral service in the early afternoon was followed by the slaughtering of a goat immediately afterwards, all of which was consumed by the mourners that evening. The goat, which was slaughtered by friends and kin of the deceased, was purchased by his widow.

One year later, in May 1970, printed invitations, some in Zulu and some in English, were distributed by the widow:

> "You are invited to attend the unveiling of the tombstone for Mr. M____, on Saturday, May ___. Requiem Mass at 9.30 am. Luncheon at 12.30 pm."

In fact, the memorial service proceedings started on the Friday evening. At 4.30 pm, a goat, purchased by the widow, was slaughtered by friends and relatives. All of the blood from this goat was collected, and to the blood was added a certain type of veld grass which, at the time, was seeding

[1] I am indebted to Mrs. L. Gumede for the account of the proceedings which is produced here.

(isiqunga), and a dark powder, bought from an inyanga. This mixture was boiled, and eaten by everyone present. The eating of the treated and cooked goat's blood was explicitly stated to be a cleansing or purification rite, and the preparation of this muti was undertaken only after the widow had washed her hands very thoroughly, as a preliminary purification measure. All of the goat's blood and the meat was consumed at the widow's home on the Friday night, and this was regarded as essential, though my informant was unable to discover the reason for this.

At the same time as the goat was killed, an ox (which had cost the widow approximately R60) was also slaughtered, and was hung up on poles for the blood to drain out of the carcase. What happened to this blood is not known, but it was definitely not used in the same manner as the goat's blood.

Early on the Saturday morning, the local women (not all of whom were related to the widow) began cooking the beef. The beef from the slaughtered beast was supplemented by more bought directly from the butcher, which was used only for stewing. Of the women undertaking the preparation and cooking of the meat, only the deceased's mother and her two sisters were his kin: all the rest were lady teachers from the mission, most of whom were preparing cold meats and salads for the luncheon. No chickens were used at all for this luncheon, or at any other time during the proceedings, and my informant suggested that the reason for this might be that the slaughtering of chickens is associated with Zionist sects.

Although the total number of people invited is not known, some sixty people actually attended the memorial service and luncheon, including the widow, the deceased's mother and her two sisters, the widow's siblings and families.

The Requiem Mass was conducted by an African Catholic priest who did not belong to the Mariannhill diocese, but who was asked to conduct the service because he was a friend of the family of the dead man. He was assisted by two European priests. From the cathedral, the congregation proceeded to the graveyard across the road, where prayers were offered and the tombstone was unveiled. Before dispersing, each person who had attended the service, regardless of religious affiliation, sprinkled Holy Water on the tombstone, following the example of the officiating priest. The whole service lasted approximately one hour.

From the graveyard, proceedings moved to the widow's house, where luncheon was served. The meal consisted of rice and the stewed beef bought from the butcher, other vegetables, cold meats and salads, puddings, cakes and cold drinks. When this luncheon was completely finished, the meat from the slaughtered ox was served, together with beer brewed some days previously by the widow and her friends. The beer was brewed in clay pots and tins.

Friends from the mission and surrounding areas began dispersing in the afternoon, but relatives who had come from further afield to attend the ceremony, did not start leaving until the evening, after the widow had distributed the deceased's belongings. Since their son was only five years old, she kept very little -- a couple of his suits, and his books. Most of his clothes were given to mentally-retarded men from the mission. Very few of his possessions went to his kin.

* * * * * * * *

In terms of elite values and behaviour, it is perhaps significant that no nurses attended this memorial service, although some were invited. Teachers, on the other hand, not only attended, but actively assisted in the preparations.

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