

**The London School of Economics and Political Science**

*Status, morality and the politics of transformation: an  
ethnographic account of nurses in KwaZulu-Natal,  
South Africa*

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# **Declaration**

I declare that this thesis is the product of my own original research.

Elizabeth Alison Hull

*This work is dedicated to my parents,  
John and Marilyn*

## Abstract

This thesis examines the ways in which a deeply entrenched nursing hierarchy is being reconfigured and challenged, and the status of nurses reshaped, in relation to wider political and social processes in the post-apartheid context. Specifically, it offers an ethnographic analysis of nurses working at Bethesda Hospital, a rural government hospital in northern KwaZulu-Natal. It argues that at this moment of liminal uncertainty characterising the current political and social transformation, nurses' experiences are made meaningful both through a nostalgic reconstruction of the hospital's missionary past, as well as through idioms that generate opportunities for – and a sense of control over – the future. These are all manifestations of a contemporary post-apartheid moment, yet they are also extensions of longer historical processes. This thesis, therefore, poses important questions about the nature of 'transition' in South Africa, and to what extent this has been marked both by rupture and continuity, in the localised context of a rural government hospital and its surrounding area.

The thesis begins with an historical account of Bethesda hospital from its inception in 1937 as a Methodist mission hospital, and its eventual transfer to state control, describing a complex and changing micro-struggle for power in the context of a wider political economy of health care. It goes on to consider the influence of the hospital's mission past on current practices, exploring the ways in which nostalgic memories feed into contemporary workplace debate. Such debate is framed by a context of severe and widespread ill-health exacerbated by the HIV/Aids epidemic, and the problems of staff shortage, fragmentation and poor pay and working conditions that provide ongoing and critical challenges to the institution and its employees. It considers how the moral concern provoked by this perceived crisis, and the preoccupation with hierarchy that has long been a feature of the South African nursing profession, are played out in relation to the emerging post-apartheid ideologies of 'accountability' and 'rights'. Finally, it explores the ways in which nurses generate a mutual sense of purpose and control, while at the same time engaging in embattled struggles for status and self-recognition, through the practices of Born-again Christianity and international migration, showing how these offer new and powerful forms of status acquisition in the post-apartheid context.

Based primarily on ethnographic fieldwork conducted at Bethesda hospital between December 2006 and October 2007, this thesis engages with theoretical discussions about social change and relationships of hierarchy within – and beyond – the workplace. Finally, it contributes to debates about the shifting fields of nursing and health care delivery in the wider South African context of immense political and social transformation.

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# Contents

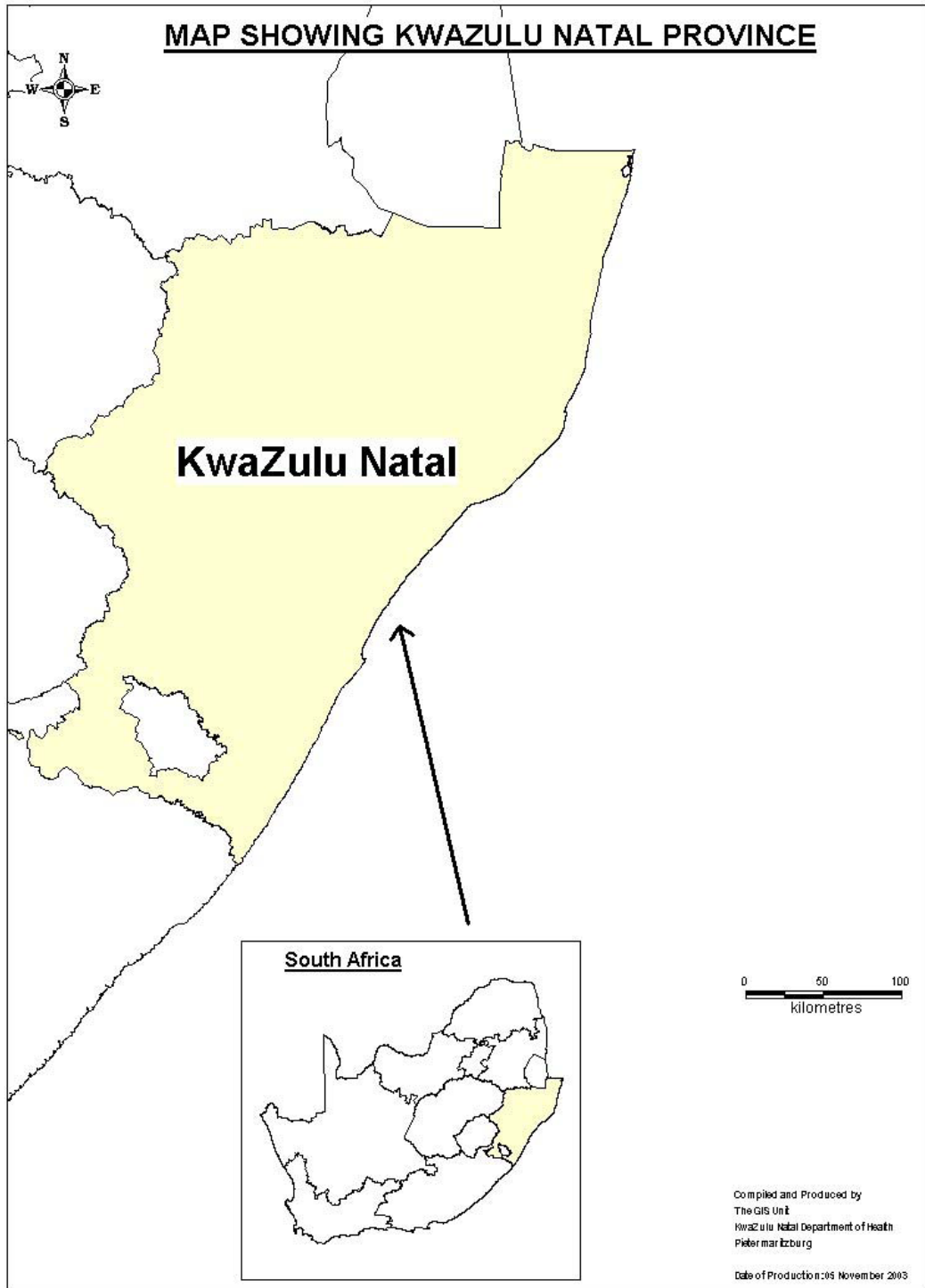
<b>Title page</b>	<b>1</b>
<b>Declaration</b>	<b>2</b>
<b>Abstract</b>	<b>4</b>
<b>Acknowledgements</b>	<b>5</b>
<b>List of maps and figures</b>	<b>9</b>
<b>Chapter 1. Introduction</b>	<b>13</b>
Respectability and professionalization	16
Christianity and secularization	22
Health care in transition	25
Consolidating the language of ‘rights’	30
Fieldwork and ethics	33
Situating Bethesda Hospital	39
Thesis scope and layout	43
<b>Chapter 2. A History of Bethesda Hospital</b>	<b>48</b>
Introduction	48
A dubious dependence: the relationship between mission and state at Bethesda	52
‘Homeland’ politics and the beginning of an uneasy transition in the 1970s	61
Nurse training, mission culture and emerging dissent	63
‘A whole-man type of ministry’: the renewal of community health amidst impending takeover	67
Inkatha and Zulu ethnic nationalism	77
A continuing missionary presence and the pursuit of primary health care after the takeover	79
Conclusion	82
<b>Chapter 3. Traversing boundaries: the ambiguous role of nurses within and beyond the workplace</b>	<b>85</b>
Introduction	85
Accounts of two nurses	92
A wider perspective: unemployment and status in Nkangala	97
The situation of nurses in Nkangala	102
<i>Household A</i>	102
<i>Household B</i>	103
<i>Household C</i>	104
Residence as the ordering of social space	106
Traversing boundaries	109
Conclusion	112

<b>Chapter 4. Workplace hierarchy, moral debate and nostalgia for a missionary past</b>	<b>114</b>
Introduction	115
Secularism, rights and generational rift in post-apartheid South Africa	119
Bethesda Hospital's missionary past and its relevance in the present	122
'We were having a calling for nursing': the past as a symbol of morality	126
Conclusion	133
<b>Chapter 5. Paperwork, bureaucracy and the contradictions of accountability</b>	<b>135</b>
Introduction	135
Managerialism and staff shortage in the post-apartheid setting	137
Accountability and hierarchy in the workplace	140
The patient file as a technology of audit	147
The production of documentation as bureaucratic culture: the example of 'Key Result Areas'	151
The separation and distancing of management	156
Conclusion	159
<b>Chapter 6. Born-again Christianity at work: hierarchies of the sacred and the profane</b>	<b>162</b>
Introduction	162
Born-again Christianity at the workplace	163
'Satan has filed that sin': Born-again discourse as social commentary	171
'He thinks that he is the child of God': gender, status and conflict in Born-again Practice	180
Conclusion	187
<b>Chapter 7. International migration, 'domestic struggles' and aspirations for status</b>	<b>189</b>
Introduction	189
Gender and migration in South African historiography	189
The international migration of nurses	195
Migratory strategies and 'domestic struggles'	199
Migration as an avenue to achieving new forms of status	202
Conclusion	209
<b>Chapter 8. Conclusion</b>	<b>211</b>
<b>Appendix A</b> Socio-economic and healthcare indicators for Unkhanyakude District	<b>219</b>
<b>Appendix B</b> Bethesda Hospital Management Organogram	<b>220</b>
<b>Bibliography</b>	<b>222</b>



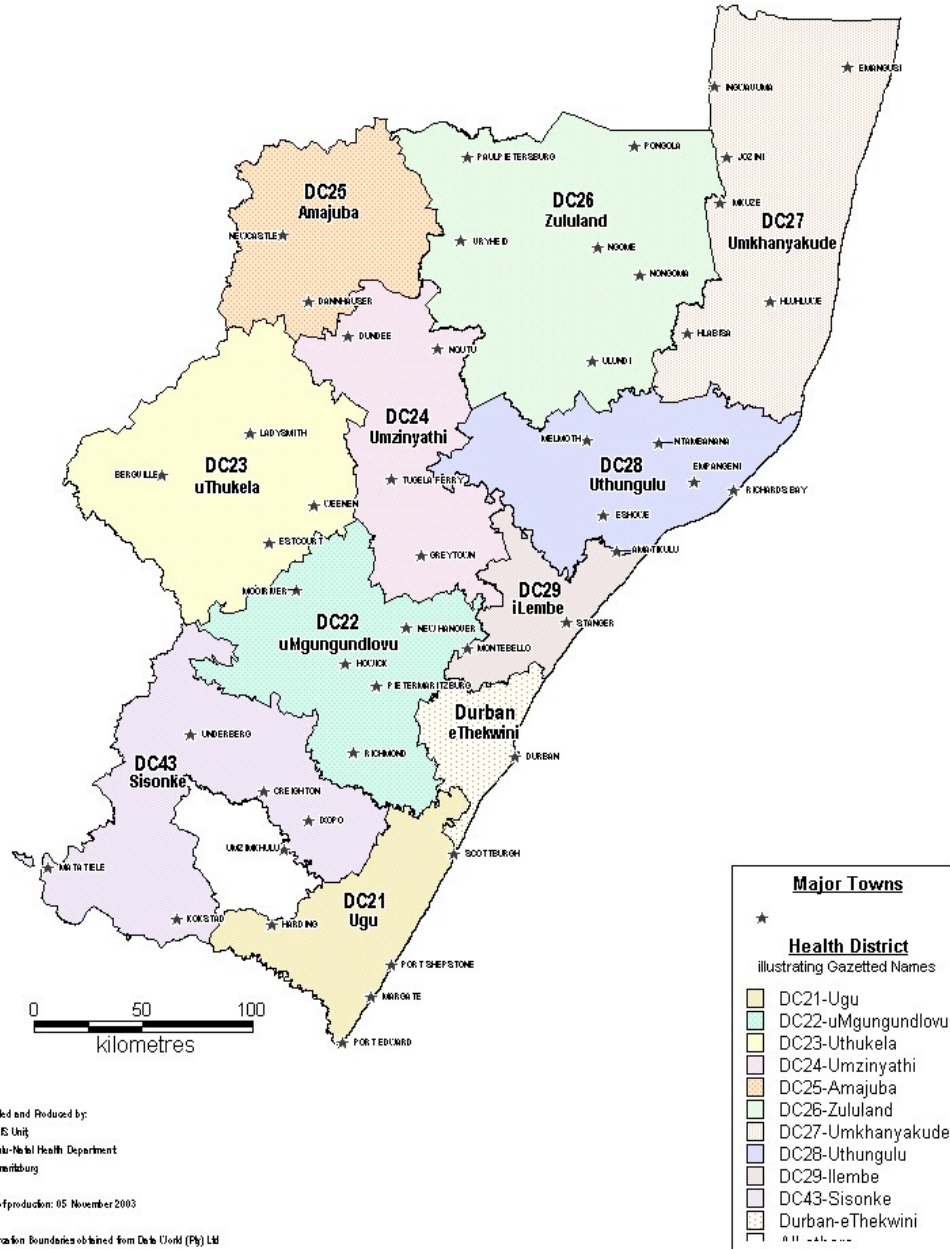
## **List of Maps and Figures**

<b>Map 1. Province of KwaZulu-Natal.</b>	<b>10</b>
<b>Map 2. Health Districts of KwaZulu-Natal.</b>	<b>11</b>
<b>Map 3. Umkhanyakude District of KwaZulu-Natal and its hospitals.</b>	<b>12</b>
<b>Figure 1. A view of Nkangala with Jozini dam in the background.</b>	<b>97</b>
<b>Figure 2. Hospital accommodation area.</b>	<b>107</b>
<b>Figure 3. Hospital accommodation: doctors' homes.</b>	<b>107</b>
<b>Figure 4. Nurses about to begin morning prayers.</b>	<b>116</b>
<b>Figure 5. Out-Patients Department.</b>	<b>118</b>
<b>Figure 6. Key Result Area (KRA) document.</b>	<b>153</b>
<b>Figure 7. Number of South African nurses and total number of overseas nurses (non-EU) newly registered in the UK between 1998 and 2008.</b>	<b>197</b>

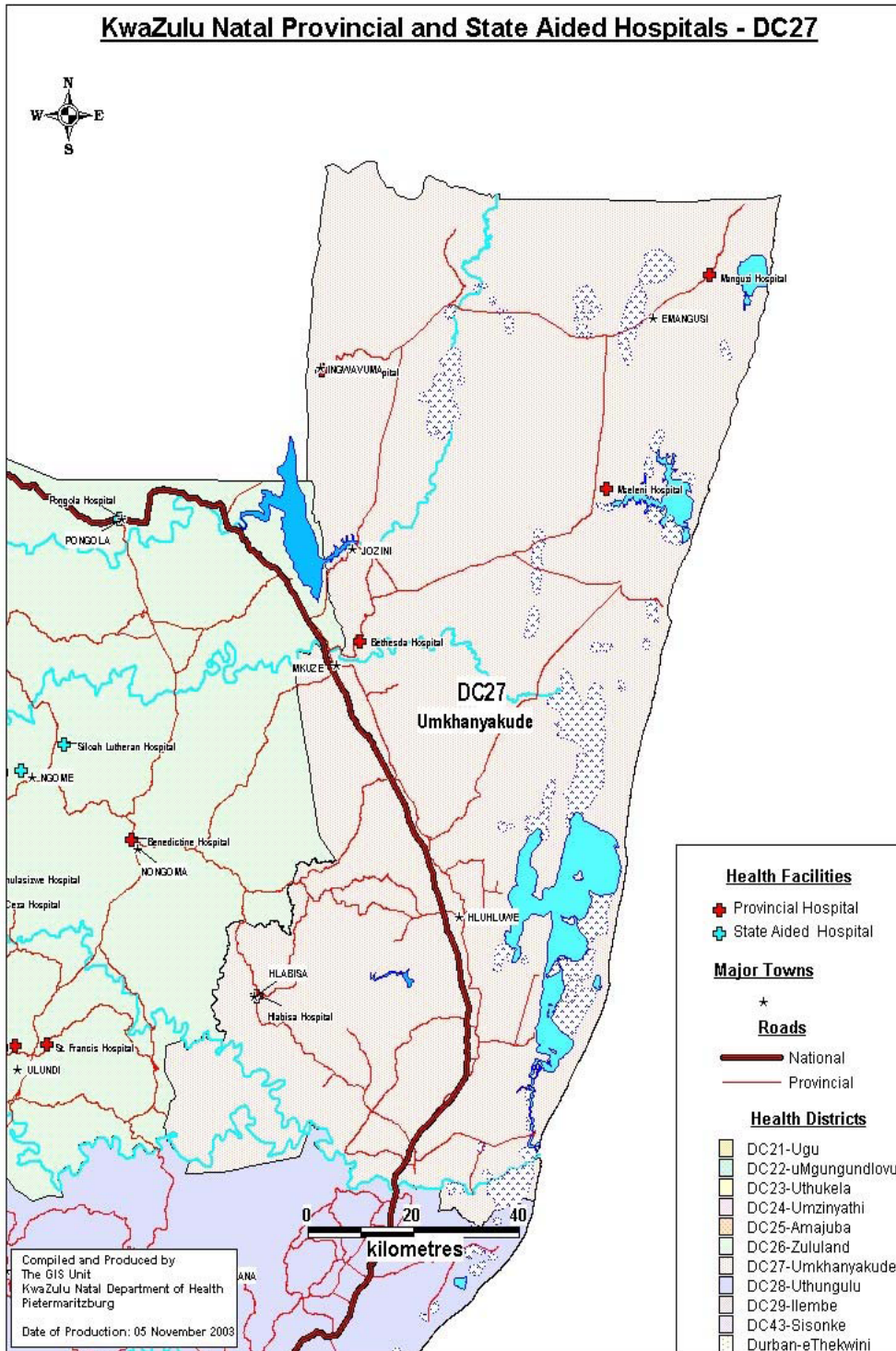


**Map 1. Province of KwaZulu-Natal**

## KWAZULU-NATAL HEALTH DISTRICTS Illustrating Gazetted Names



**Map 2. Health Districts of KwaZulu-Natal**



Map 3. Umkhanyakude District of KwaZulu-Natal and its hospitals.

# Chapter 1

## Introduction

‘You nurses are drinking our blood!’ shouted a young trade union representative, as he stood in front of a crowd of two hundred or so nurses and hospital labourers gathered outside the locked gates of Bethesda Hospital on a windy day in June 2007.<sup>1</sup> The countrywide civil servant strike had lasted for the whole month and union activists travelled across the province of KwaZulu-Natal to encourage workers to join the strike. At Bethesda Hospital, no-one did, apart from a few who picketed for an hour at lunch time on certain days: a time slot allocated, and officially approved, by the Hospital Manager.

For the duration of the strike, nobody came to work in uniform for fear of being identified by trade unionists and forced outside to strike, or worse. Devoid of their neat blue and white uniforms and the familiar epaulettes that signified their professional status, the nurses blended strangely into the wider corpus of patients from whom they were usually so starkly separated. Intermittent rumours circulated around the corridors and wards of the hospital, that ‘they are coming!’ referring to the anonymous young men who threatened to break through the locked gates and reinforced security at the entrance of the hospital, ostensibly to seek out those who were working. One night there was a tussle at the gate and an attempted break-in, allegedly by one of these militants.

On the large notice board attached to the wall outside the main entrance of the Out-Patients Department hung photocopied newspaper articles detailing various events relating to the strike. Amongst them, the bold headlines stood out: ‘As more and more unions back the Big Strike, get ready for Chaos’, ‘Teachers to Shut Down Hospitals’

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<sup>1</sup> He was representing the Congress of South African Trade Unions (COSATU). This is the largest trade union group in South Africa, and has close political ties with the ruling African National Congress (ANC) after a Tripartite Alliance was formed between them and with the South African Communist Party (SACP) in 1994. COSATU’s allegiance to the ANC has since weakened, particularly during Mbeki’s presidency when the government embraced free-market, neo-liberal economic policies provoking considerable controversy. See, for example, Feinstein 2009.

and ‘Baby dies after nurses refuse aid’. Regular statements by the head of the KwaZulu-Natal Department of Health contained similar messages, condemning the strike: ‘We must always remember that health is a human rights issue’, she boldly claimed.<sup>2</sup>

Echoing the somewhat moralising tone of most media coverage, nurses at Bethesda explained why no-one was taking part in the strike at Bethesda. Striking will ‘lower my dignity’, one said. For another, the strike was evidence that ‘there is a lack of self-discipline in nursing today’:

It is because it is specified in our code of conduct that nurses are not supposed to strike. It is because we are working with human beings. Once you leave that person unattended, you say that they can die. You are a union yourself, to your patient [Like a trade union, nurses must represent and support their patients]... Before, we respected the South African Nursing Council as our employing body and respected the decisions that they made.

This was a view replicated by a union representative working at Bethesda who, like others employed in senior positions, took the management line of opposition to the strike: ‘people worry about patients because nursing is an essential service. You cannot replace your life’. As a union representative, he saw his main role as ‘making people aware’ of the individual consequences – their potential dismissal – of strike action. For many nurses, therefore, the reluctance to strike was simply to do with their fear of dismissal. For others still, their avoidance of the strike was informed by the recent history of violence that marred the countryside of KwaZulu-Natal and that forged a close association between political activism and the repression and violence which, at that time, had accompanied it.

To anyone familiar with the history and politics of labour unrest in apartheid South Africa and the public debates it generated, this account will be only too recognizable. Yet, in a post-apartheid context, familiar ideas may well deserve renewed attention. The scene is an interesting instance with which to begin this thesis, because it is at such heightened moments of political tension that anxieties – usually forming an undercurrent below the surface of day-to-day activity – emerge and meet each other in open contestation. These anxieties, many of them concerning what is to happen in the future, also reveal central themes which have continuities with the past. One expressed in this narrative is the strong moral discourse of the nursing profession that demands

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<sup>2</sup> For the full statement, see <http://www.kznhealth.gov.za/mediarelease/nyembezi.htm>

unified allegiance even as internal hierarchies maintain significant distinctions in levels of material remuneration and the status claims of nurses (Rispel & Schneider 1991). Another is the public perception of nurses as cruel or heartless, an image that has often been generalised through media focus on particular incidents.<sup>3</sup> Related to this is nurses' perceived status and separation from a wider (working-class) community to which they are nonetheless tied to a greater or lesser extent.

For some nurses, the strike signalled changes that were imagined to be relatively new. They emphasised the moral deterioration of the profession, the lack of 'respect', 'dignity' and 'self-discipline' that are seen to characterise the profession in contrast to an earlier period. As will become clear, these fears have a much longer trajectory in South Africa's nursing history, even if they are imagined as having only recently emerged. Such laments, buttressed by media representations that depict a process of deteriorating care in the health system, also express a sentiment widely shared by nurses and the wider public at the current time. To move beyond such assumptions demands that questions be asked about the forms that such discussions take, the purposes they serve, and the processes which they represent – sometimes in caricatured form - in the current context of wider social change.

The strikes generated a degree of perceived 'abnormality' in the daily interactions of the hospital, blurring the patient-nurse interface (visually and symbolically), whilst simultaneously reinforcing the hospital's physical discreteness from the outside world through the reinforcement of its physical boundaries. Yet both emphasised the vulnerability and porosity of such boundaries, between the inside and outside of the hospital, between the positions of 'civil servant' and 'private citizen' (Gupta 2005), and between the unionists who invaded the moral sanctity of patient 'rights' on the one hand and the nurses who 'drank the blood' of the struggling populace on the other.<sup>4</sup> It is this blurring of boundaries, and these contingent factors, that belie the fixed stereotypes and representations of nurses in South Africa.

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<sup>3</sup> In 1965, Hilda Kuper reported a similar antipathy towards nurses, noting that they received disproportionate blame for patient dissatisfaction, and arguing that 'generalizations of cruelty or neglect of patients have not been substantiated, and undue publicity has been given to isolated incidents' (H. Kuper 1965: 223-4).

<sup>4</sup> This image evokes an array of meanings in the African context. Ferguson argues that the prolific ideas of cannibalism, bloodsucking and witchcraft are related to a conception of wealth that is bound together with social relations. There are 'two kinds of wealth', he argues, 'the kind that feeds people and the kind that eats them' (Ferguson 2006: 73).

Historically in South Africa, nurses have occupied a dangerous and liminal space, claiming membership of an elite class whilst being downgraded within their own, highly stratified and racialized, profession (Marks 1994: 12). Such ambiguities remain salient in the contemporary context. This thesis seeks to address the ways in which these categorisations and hierarchies are reconfigured and challenged, and the status of nurses reshaped, in relation to wider political and social processes in the post-apartheid context. Crucially, such processes entail both continuities with the past and significant changes.

### **Respectability and professionalization**

The strong moral discourses that have frequently characterised debates within the nursing profession have their roots in Christian values of respectability dating back to the establishment of modern nursing in South Africa. From the 1870s, nursing services were provided predominantly by religious sisterhoods, and were accompanied by a very particular ethos modelled on Victorian notions of femininity and Christian duty. This was later to contribute to the elite social status associated with mission-educated nursing for young black women at a time when very few comparable avenues existed. The search for status and the construction of moral identity within the nursing profession, at times, generated immense tensions and divisions between its members.

In her key work on the history of nursing, Shula Marks (1994) describes the fraught development of the profession since its inception in South Africa in the late nineteenth century. Western forms of medical and nursing practice were initiated mainly by religious sisterhoods, partly in response to the widespread ill-health induced by poor working and living conditions that became so prevalent in mining towns and settlements following the mineral discoveries of the 1970s. Sister Henrietta Stockdale, who established a nursing school in Kimberly in the 1880s, emerged as a key figure of this period. Her work – that included creating modern training standards as well as providing a charter for the profession – ensured her significant influence on the early development of the profession and her subsequent status as the founder of modern



nursing in South Africa, assuming an image much like that of Florence Nightingale in Britain (ibid: 15).

In the 1870s and 80s, nursing was dominated primarily by English women who migrated to South Africa to fulfil the higher demands of health care brought about by industrial change. With them they brought the image of the 'lady nurse', which embedded ideas about caring as intrinsically linked with femininity and moral duty: 'not only would the sisterhood provide nursing care; their purity and devotion would provide the necessary moral example' (ibid: 25). The idea of the nurturing female role, a quintessential aspect of nursing, was reinforced by propaganda from the colonial government that, drawing on these images, insisted on the god-given duty of all women to provide care, as part of a broader colonial strategy of managing labour resources.

The superior status and cultural refinement associated with these nurses made a powerful imprint on the image of the profession in South Africa, as it did in Britain, and rendered nursing an alluring option for many South African women, both black and white, from the early decades of the twentieth century. Nurses came to represent the desired transition to western forms of medicine and health care that was deeply embedded within a broader moral and ideological project of 'civilizing the natives' and that depended upon the eradication of 'superstitious' and 'ignorant' traditional beliefs. Therefore, as Marks describes, black nurses that were trained at this time constituted the ideal colonial subject. They were 'harbingers of progress and healing in black society, a shining light in the midst of its savagery and disease' (Marks 1994: 78).

From this early stage, then, nurses gained access to the privileged status that set them apart from a wider African population. Various authors have described the emergence of an African elite class under British colonialism and, later, apartheid (Brett 1963; Wilson & Mafeje 1963; L. Kuper 1965; Brandel-Syrrier 1978; Dreyer 1989; Cogley 1990; La Hausse de Lalouvière 2000; Thomas 2006). The status aspirations of nurses were part of this broader social and historical process. Showing how this was rooted in the early missionary movements of the mid-nineteenth century, Robert Ross (1999b) gives a nuanced historical account of the emergence of the idea of 'respectability' as a signifier of status in Africa. Tracing the importance – and meaning – of status amongst upwardly aspiring Africans, Ross describes the association that was forged initially between Christian conversion and respectability. Through a hegemonic process

involving the dissemination of Christian ideas and values, the concepts of worldly prosperity and spiritual salvation became synonymous such that the merging of these values into a single civilising project meant that salvation could not be attained through conversion alone, but through a wholesale adaptation of lifestyle and material acquisition; a ‘reformation of manners’ (ibid: 337). Thus as one missionary stated, civilization was achieved only if “you lived in such homes as Englishmen live in, dress, and walk, and use knives and forks like Englishmen” (ibid: 339). Deriving from the missionaries’ moral rejection of slavery and the corresponding desire to help ‘natives’ to gain improved living standards, respectability became the major means through which civil rights and material prosperity might be achieved. As others have shown, medical missions were part of this wider missionizing effort, with Western medicine and physical healing closely associated with the project of spiritual healing and salvation (J. & J.L. Comaroff 1997; Hunt 1999; Hardiman 2006). Nursing was an essential component of this. Marks suggests that ‘no profession was more associated with the beneficent work of the missionaries than nursing; African nurses themselves were the elite of their community and seen by many whites to be the most progressive of their people’ (Marks 1994: 189).

A small group of black elites had emerged in South Africa by the 1920s for whom ideas and values of respectability had, by this point, acquired considerable cultural significance. This is described in detail by Alan Cobley, who argues that the appropriation of ‘Westernised’ patterns of behaviour, dress and lifestyle constituted outward signs of status, enabling the group to achieve ‘social closure’ to compensate for their inability to guarantee this status through their political and economic situations (Cobley 1990: 70). Due to the racist policies and ideologies of the state and the subsequent constraints that this had on upward mobility for black people, such as the colour bar that prevented them from occupying certain positions within the job market, incorporation of Western ‘style’ was harboured as a means of stabilising their otherwise volatile social position.<sup>5</sup> Nurses were strongly associated with this group: ‘by the 1920s

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<sup>5</sup> Anthropologists have engaged in a longstanding debate about the meanings and incentives for Africans of appropriating Western-style clothing and consumption habits. While the Rhodes-Livingstone scholars saw it as a way to access the ‘civilized’ world (e.g. Mitchell 1959) later scholars claimed it offered a mode of resistance or, like Cobley, access to a desired urban lifestyle. See Burke 1996 for an example from Zimbabwe, and Thomas 2006 in relation to South African women seeking ‘respectability’. For an extended summary of this debate, see Ferguson 2006, Chapter 6, ‘Of Mimicry and Membership: Africans and the “New World Society”’.

nursing had clearly become an acceptable and highly prestigious occupation for the daughters of the westernised elite' (Marks 1994: 88).

Yet, as Marks shows, whilst black nurses were undoubtedly attracted to the respectable standing offered by their profession, they simultaneously found themselves precariously positioned within a profession dominated by the racist and discriminatory practices of a white elite deeply concerned with the advancement of their own professional status. An initial desire from some sectors of the profession to exclude black women altogether was soon abandoned due to the increasing levels of ill-health and demands for health care, a pressure that gathered pace in the 1940s. As apartheid gained momentum following the success of the National Party in 1948, a series of segregationist and discriminatory policies in the form of the 1957 Nursing Amendment Act finally – despite the rapid increase of black women entering the profession by this stage – ensured the solidification of apartheid ideology within the nursing profession (ibid: 159).<sup>6</sup>

The drive for professionalization in nursing has not been restricted to South Africa. Based upon a longstanding desire for equal recognition alongside medicine, nurses' aspiration to professional status has been documented internationally (Levi 1980; Coburn 1988; Forsyth 1995). The subordination of nursing to medicine finds its symbolic roots in the gendered associations between nursing and domestic labour (eg. Gamarnikov 1978; Littlewood 1991; Savage 1997). Eva Gamarnikow, for example, argues that the ideological equivalence between the nurse-doctor and wife-husband relationship functions so that the sexual division of labour is justified by its analogy with family structure and patriarchal marital relations. Thus being a 'good nurse' and being a 'good woman' is coterminous. Nursing as a whole, as a feminine profession, has therefore developed in subordination to the implicitly male profession of medicine. She quotes Florence Nightingale: "We nurses are and never will be anything but the servants of doctors and good faithful servants we should be, happy in our dependence which helps to accomplish great deeds" (Gamarnikow 1978: 107). The ethos of nursing has been cast in moral terms therefore, naturalised by a perception of womanly qualities of loyalty and obedience, rather than being based on skill or technical knowledge.

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<sup>6</sup> For a full discussion of this, see Marks 1994, especially Chapter 6: "A Taint on the Flower of Womanhood in South Africa".

This gendering of the profession has been all too apparent in the South African context. However, in South Africa as elsewhere, discourses of professionalism have attempted to dissociate nursing from its womanly and domestic connotations by placing an emphasis on the technical and medical skills of nurses, turning nursing into an academic field and emphasising it as 'separate from, but equal to, medicine' (Rispel & Schneider 1991: 111). This effort to challenge the superiority of the medical sphere has nonetheless been persistently undermined by the fraught nature of a profession divided not only by gender but also by the particular features of race and class in the South African context, that have served historically to reinforce its intense preoccupation with status and hierarchy (Marks 1994). Yet even these elements have often remained implicit, or been downplayed, for the sake of presenting the profession as united in its claims to senior status. A prominent nurse educator and academic, Grace Mashaba, in her historical account of black nursing in South Africa (1995), focuses upon the processes whereby black nurses have 'scaled the heights' of academia and achieved a level of professional success comparable to that of their white colleagues. Given this central aim of showcasing the successes of black nurses, her book is less concerned with the structural dimensions that held them back or that placed them at a disadvantage, although passing mention is made to such factors (ibid: 49).

The image of unity expressed by the proponents of professionalization is undermined by the actual experience of most nurses in South Africa, one characterised by a lack of control and autonomy, a fragmentation of tasks and therefore a deskilling of individuals that has produced an increasing stratification within the occupation itself. This downgrading of a significant proportion of nurses has, for the most part, failed to result in any organised resistance because, it is argued, the ideology of professionalism, serving as a kind of hegemony, asserts that 'every level of the hierarchy is united in solidarity and defence of the nursing profession' (Rispel & Schneider 1991: 119), despite the growing disparity of wages and working conditions between nurses at different levels (cf. Webber 2000).

Thus, the peculiar complexities arising from the intersections of class and race in South Africa meant that throughout the development of the nursing profession, the emergence of an elite African 'respectable' group occurred alongside a persistent downgrading of black nurses *within* the professional hierarchy. This contradiction has produced two extremely contrastive images of nurses that pervade public representations and that are

also reflected in the literature. One depicts nurses as occupying a largely elite category (e.g. Cheater 1972) and the other portrays them as downgraded and disempowered workers (e.g. Webber 2000). This division became much more stark following the huge expansion of the profession in the 1970s, when the vast majority of nurses occupied subordinate positions within the ranks. This eventually contributed to the massive unrest, unionisation and industrial action that took place in the 1990s (Marks 1994; Webber 2000).

This contrastive image of nurses continues to dominate the public imaginary. In the opening scene of the strike, for example, the unionist's reproach that nurses were 'drinking our blood' implied a greediness and a rapacious consumption of public wealth, whilst among themselves, nurses bemoaned their poor wages and difficult working conditions. Such dichotomous representations are reconstituted in particular ways in the post-apartheid context, where the Christian associations that underpinned ideas of respectability are giving away to different types of status formation, and the rapid expansion of education to Africans has ensured that nursing students are drawn from increasingly diverse backgrounds, no longer the reserve of English-speaking, Christian families.<sup>7</sup> I am not suggesting that this shift has taken place only since 1994; on the contrary, as Marks shows, throughout the twentieth century the widespread demands for health care and the often indiscriminating recruitment drives persistently undermined the profession's ability to preserve itself as an exclusive and elitist occupation. But, given the huge expansion of health care since 1994, as well as the formal eradication of racial discrimination and an increasing focus on labour rights, this is a process that has continued apace, even intensified. The meanings of, and avenues to achieving, nurse status have shifted as a result, and debate and competition have been generated over its symbols, both within the internal hierarchy of the profession and within the context of a wider, transforming society.

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<sup>7</sup> The persistence of a dual system of nursing education, however, in which some go through the hospital-based, nursing college route whilst others achieve the more reputable university degree, has ensured that stratification in the education of nurses remains prominent.

## **Christianity and Secularization**

The ongoing tensions produced by conflicting images of nursing both as an elite profession and as a basic hands-on job has been imagined, in part, through a religious/secular dichotomy in which nurses have been represented, on the one hand, as Christian, caring, compassionate and beneficent and, on the other, as unskilled workers motivated primarily by financial concerns. Such ideas were reinforced and perpetuated by key figures in the profession such as Charlotte Searle. For much of the twentieth century, and particularly during the apartheid era, Searle was the most prominent educator and scholar of nursing, and the most influential nurse in the country. She wrote extensively about her profession and contributed profoundly in shaping it. She was also a leading proponent of professionalization, a position that motivated considerably her outlook and contribution to nursing. She wrote of the earliest 'secular nurses' in post-reformation Europe:

They lacked the strict disciplinary control to which the members of the religious orders had been subjected, and they also lacked the cultural refinement of the religious sisters. The monks and nuns had worked in the hospitals for religious reasons and on humanitarian grounds, but the new type of nurse came into hospitals for economic reasons (Searle 1965: 134-5).

This quote hints at a dichotomous representation that found cultural footing initially in the missionary context in Africa, later to influence the development of nursing throughout the twentieth century. Yet it is equally laden with Searle's own assumptions about the relationships between class ('cultural refinement'), religious calling and her idea of proper nursing, drawing on the perceived moral and status differences that separated 'religious' from 'secular' nurses. For her, the prospect of secularism in nursing undermined its integrity and moral standing.

Throughout the twentieth century, ideas of Christian duty were thus twinned to a search for professional prestige, accompanied by a moral condescension towards those who appeared to be doing the job for personal gain. The latter was most often associated with the lower rank and file of nursing who were often impugned for undermining the reputation of the profession, by going on strike for example, regardless of the enormous disparities that separated its different levels (Marks 1996: 196). Questions of religion and secularism were, therefore, intimately bound up with the ongoing struggle for professionalization within a framework of intense stratification.

Among nurses at Bethesda, this religious/secular dichotomy has been indexed by the historical transition of the hospital from mission to state control. Formerly run by the Methodist Church of South Africa, Bethesda was taken over by the government in 1982, representing one instance of a wider secularization of health services in South Africa, a process I explain in detail in Chapter 2. The encroaching role of the state and the concurrent diminishing influence of mission hospitals fed into the moral discourses described above in particular ways. This thesis addresses these processes and their influence upon contemporary constructions of workplace status and morality at Bethesda Hospital, examining to what extent religious idioms still play a role in defining nursing ethos and identity.

What is important to note, at this stage, is that the debates with which nurses engage, that are an ongoing expression of the particular history of the nursing profession, also emerge in relation to a more general socio-political trajectory. Occurring alongside the encroaching role of the state at Bethesda, for example, was an increasing bureaucratisation and complexification of health services in South Africa more generally, that also influenced the internal dynamics of the nursing profession in particular ways. The technological advancements of medicine and health care provided nursing with an opportunity to fashion itself as a ‘science’, equivalent to that of medicine. Yet it also presented a perceived threat, seemingly undermining the implicitly gendered and religious associations of nursing that encouraged womanly ideas of moral duty, care and compassion.

The tension between these two competing visions was revealed by Charlotte Searle in an address to the Department of Nursing Science at the University of Pretoria in 1968:

If the nurse is a mere “paid” worker, she will fail man in his moment of greatest need; if she is merely “charitable” and unable to contribute to his therapy, she is a danger, and if she is a mere “scientist”, the support needed by those who are vulnerable will be lacking. Scientific developments in medicine present a great challenge to nurses, not merely at the level of the acquisition of knowledge, but also at the level of interpersonal relationships and ethical values ([1968] 1980: 3).

Her comment expresses the seemingly contradictory ideas of nursing as a morally imbued and compassionate, caring pursuit, and as a scientific occupation akin to that of

medical doctor. She expresses this sentiment more explicitly later in the address, outlining the dangers of the latter approach:

The mass of medical material, the emphasis on cause and effect in a scientific study such as medicine, burden the nurse with a sense of guilt because she permitted the demands of science to smother her humanitarian role and in this way to desert her patient. Since we nurses are aware of this, we want to take up the challenge of this scientific age. We realise that our greatest challenge is to ensure a balance between the demands of science and the demands of the individual. Nurses realise that the greatest threat of this technological age is that medicine may be deprived of its humaneness (ibid: 14).

Here she outlines a careful compromise, willing to forego neither the Christian underpinnings of nursing consolidated during the mission era, nor the professional, scientific status accessible to nurses in a new 'technological age'. The moral side of nursing, that 'humane' approach offered exclusively by the nurse, was closely twinned to the Christian moral ethos described above in which nurses were 'to moralise and save the sick, not simply nurse them' (Marks 1994: 208). Indeed, it was this that earlier set nurses apart as an elite social category. The bureaucratisation and complexification of health services thus fed into discourses about the perceived moral decline of the profession and simultaneously challenged the status gains made by nursing thus far. It threatened to swamp nursing with government demands and standardising procedures, thus transforming it into a set of technical procedures dictated by the state. Nursing was at risk of becoming an unremarkable and functional branch of an increasingly centralised health system:

The impersonal nature of a government-organised service dominated by bureaucratic ways of thinking... has been responsible for periods of decline in the quality of nursing. The bureaucrat views the nurse as a mere pair of hands that daily have to perform the prescribed stereotyped procedures. To him – be he doctor or layman – the uniqueness of the sick person and the personal support required by him have no meaning (ibid: 7).

Although Charlotte Searle represented the highest echelons of the nursing profession, separated from the vast majority of her colleagues both by race and by class, her comments nevertheless reflected and reinforced dominant ideas, speaking to deep-seated concerns that have reverberated throughout the spectrum of nursing in South Africa, and re-emerge in the contemporary context of Bethesda Hospital.



Yet this interplay between race, gender and Christian belonging, that initially set the terms by which nurses' status was measured, was to be reconstituted differently in relation to the democratic transformation and the wider public discourses of the post-apartheid period. One significant factor was the rapid changes implemented in the health sector, and the increasing pace of bureaucratisation which Charlotte Searle had anticipated many years previously. These give her words a particular resonance at the time of writing. In order to understand this changing world in which nurses' identities are being reconfigured, I turn now to a brief examination of this wider transitional process in South Africa's health care system since 1994.

### **Health care in transition**

The changing experiences of nurses at Bethesda must be understood against the backdrop of transformations in health care in South Africa since 1994. A brief look at the key changes gives an indication of both the extent to which nurses are embedded within and affected by the broader social context, and the extent to which they are simultaneously involved in constructing a reality which incorporates or challenges these on their own terms, in a manner informed by the specificities of debates within nursing.

In 1994 the newly elected African National Congress (ANC) inherited a weak health care infrastructure, characterised by excessive public spending on tertiary hospitals rather than primary health care, and by the directing of a disproportionate amount of funds at a minority via the large and poorly regulated private sector (Schneider & Gilson 1999). Apartheid health care provision was, in certain respects, extremely advanced but this technologically developed and specialised care was largely inaccessible to anyone outside of the white population and was facilitated by a disproportionately high budget allocation (De Beer 1984; Jinabhai *et al.* 1986).<sup>8</sup> In 1994 and 1995, the 14 separate departments of health – including ten that had been controlled by the 'homeland' governments – were integrated into a single, unified health

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<sup>8</sup> A small proportion of black South Africans did benefit by the late 1980s because of private insurance schemes paid by their employers. But the majority were excluded from such benefits (personal correspondence with Shula Marks, 29<sup>th</sup> Sep. 09).

infrastructure.<sup>9</sup> District Health Systems (DHS) were set up, although it was not until the National Health Act of 2005 that the national, provincial and district levels of health care organisation were consolidated (Schneider *et al.* 2007: 296-7).

Whilst it is widely acknowledged that considerable progress has been made in South Africa's health care system over the last 15 years – including the expansion of primary health care in rural areas and much improvement in reproductive health services (McIntyre *et al.* 2006: 442) – many point to the continuing inequities that have yet to be overcome, as well as to a range of obstacles that undermine the overall effectiveness of the health care system. Several of these impact heavily upon the daily working lives of nurses and upon the particular frontline institutions of health care delivery.

Firstly, as is now well-known, the Aids epidemic has placed an enormous strain on South Africa's health system in recent years. Given its untimely coinciding with liberation, Aids has come to represent, more than anything else, the ambiguities and contradictions of transition in public moral discourse and, for many, has brought painfully into view the erroneous assumptions underlying the idea of a 'new' South Africa (e.g. Feinstein 2009: 116-9). Of the total population of 48.2 million, an estimated 5.7 million people are living with HIV in South Africa.<sup>10</sup> KwaZulu-Natal in particular has an extremely high burden of disease, measuring an HIV prevalence rate of 32.5 in 2007/8, compared with the national rate of 24.4, making it the highest of all the provinces (Day *et al.* 2009: 161). For nurses, this situation generates not only an unmanageable workload, but is a source of deep and pervasive moral concern. While this thesis is not focused upon the medical or social factors related to the Aids epidemic specifically, its catastrophic effect has produced an underlying and profound anxiety which gives moral discourses heightened intensity.

Secondly, a variety of difficulties emerged after 1994 in the process of restructuring the health care system. Whilst the initial stage of integration was largely successful, numerous weaknesses at the provincial and district levels have generated ongoing inefficiencies in attempts to bring about an effective decentralised system. These have

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<sup>9</sup> The 'homelands', or bantustans, were territories set aside by the apartheid government for the purpose of creating ethnically homogenous, independent states for South Africa's black ethnic groups. Ten were created altogether.

<sup>10</sup> See [http://data.unaids.org/pub/FactSheet/2008/sa08\\_soa\\_en.pdf](http://data.unaids.org/pub/FactSheet/2008/sa08_soa_en.pdf)

been categorized according to a distinction between ‘systems weaknesses’ which include a lack of skilled personnel and low managerial capacity, and ‘structural weaknesses’ referring to the problems of communication between different departments and scales. Related to the latter, a subsequent lack of accountability has been blamed on the complex overlapping of various government structures at district, provincial and national levels. ‘Structural’ problems also include, for example, the low income-generating potential of districts located in areas of high unemployment and poverty, and the limitations that this places on service delivery in those areas where local governments are expected to provide (Pycroft 2000: 147-8).<sup>11</sup> Others have looked beyond these rather technical features of delivery restructuring to their wider political ramifications, focusing on the lack of participation and ‘active citizenship’ that subsequently undermines the very purpose of decentralised governance (Mathekga 2006).<sup>12</sup>

Thirdly, a policy of fiscal restraint adopted by the ANC government has called into question the potential of the state health care system to provide the extensive services required. Schneider *et al.* suggest that ‘staying within budget became and remains the key preoccupation of managers, implicitly relegating equity and other dimensions of institutional change to secondary goals’ (2007: 297). This prioritising of financial containment was motivated by a national shift in the macroeconomic agenda in the late 1990s in line with the prevailing international norms of public economic management, when the ANC adopted a controversial programme – known as the Growth, Employment and Redistribution strategy (GEAR) – that favoured fiscal control, trade liberalisation and the promotion of foreign investment, productivity and export competitiveness, in an attempt to situate and stabilise the South African financial system within a wider global economy. Whilst some maintain that this was an essential move, many are more critical, showing how it has resulted in an economy characterised by severe unemployment and prevailing inequities (Marais 1998; Chopra & Sanders 2004; Southall 2007). In health care, some authors argue, inequalities have deepened, particularly in the context of a growing private sector, whilst decreasing government expenditure and an array of policies focusing on cost efficiency and deficit reduction targets has led to the ‘stagnation’ of public health care financing (McIntyre *et al.* 2006:

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<sup>11</sup> The problem of decentralisation to local government bodies with low capacity is not specific to health care but to all aspects of state delivery e.g. water supply (Muller 2007).

<sup>12</sup> Many of these issues are not specific to South Africa. For a discussion of similar obstacles of decentralisation in a Latin American context of political transition, see Rosenbaum *et al.* 2000.

436). A shortage of human resources has been one of the most serious outcomes, and places a considerable strain on the health system nationally.

The justification for the adoption of the neo-liberal approach offered by GEAR, was to stave off currency devaluation and to enable the survival of the national economy in a global marketplace. But the signs, at least as far as health care is concerned, suggest that this strategy has not reaped the intended benefits (McLennan 2007b). More recently, some have suggested that this looks likely to improve, with promises of greater financial assistance to the health sector (Von Holdt & Murphy 2007: 337). Indeed, many people across the country are hopeful that the newly elected president, Jacob Zuma, may shift national politics towards a more redistributive agenda and one less driven by market ideology. Whether this will happen remains to be seen.

Finally, alongside this economic strategy came the application of business objectives to the public sector – such as cost reduction and productivity – and the emergence of an institutional language of accountability, audit, customer choice and managerialism. It was hoped that strengthening such mechanisms would enable a cutback of government spending. Thus, paradoxically, the rapid integration and expansion of state welfare following the end of apartheid coincided with an increasingly influential international orthodoxy promoting the downsizing of government and fiscal reductionism and, as we have seen in the UK and many other countries in recent years, the incorporation of business principles and strategies within the public sector. The economic and ideological arguments go together, as Pycroft suggests: ‘South Africa’s move to embrace the global economic orthodoxy embodied by GEAR is replicated by its efforts to embrace the global orthodoxy of new public administration’ (Pycroft 2000: 156).<sup>13</sup>

What is important here is the way in which such strategies, and their accompanying rhetoric, are received in the context of the specific institutions of health care delivery, and by those responsible for providing frontline care. Despite the enormous bureaucratic machinery put in place to manage the transformation, South Africa’s public institutions tend overall to suffer from low bureaucratic capacity (Bateman 2006). This is to do with the fact that complex policies and administrative models have been placed on top of

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<sup>13</sup> Gow & Dufour (2000) discuss some key aspects of ‘New Public Management’ in contrast to the classic bureaucratic ‘Public Administration’ approach that is widely asserted as its competing paradigm.

existing delivery systems without sufficient strengthening of the latter (McLennan 2007a; Schlemmer *et al.* 2004). In the absence of adequate skills or a strong enough resource base, the heavy reliance on managerial efficiency has proved largely unsuccessful, dependent upon an autocratic and centralist form of governance that places excessive demands on managers who lack the sufficient resources to carry them through (Von Holdt & Murphy 2007). Some authors argue, therefore, that the emphasis on tightening up managerial practice, ironically, has reinforced a hierarchical model of governance that has for long characterised health care practice in South Africa. As Wenzel claims, 'if there is a dominant reality in the practice of public administration, it is the persistence and endurance of the traditional model of governance, its hierarchy and rules, and its preoccupation with organogrammes and statutory mandates and with superiors' permissions' (Wenzel 2007: 50). Decentralisation thus seems to have entrenched a hierarchical order in the workplace without the resources to significantly improve delivery.

Others studying health care on a smaller scale, from within particular institutions and from the perspective of health workers, envisage the South African health service as occupying a kind of liminal state: the old apartheid work regime has disintegrated, without the formation of a new workplace logic taking shape on the ground, even despite attempts to reinforce a new ethos of managerialism (Von Holdt & Maserumule 2005; Von Holdt 2005). The sense of intense work pressure accompanied by liminal uncertainty about the future was summed up by a nurse at Bethesda when she said: 'We are in a rush, but we don't know where we are rushing to!' The autocratic emphasis upon hierarchy provoked by the new managerialism is sometimes suggestive of the authoritarian apartheid work order, especially given the apparent fixity of medical and nursing hierarchies in the health context. Yet, as Burawoy & Verdery suggest, what appears as a stubborn clinging to old practices, and a resistance to embracing the 'new', may in fact be 'direct *responses* to the new market initiatives, produced *by* them, rather than remnants of an older mentality' (Burawoy & Verdery 1999: 2). The breakdown of macrostructures that comes about during massive political transition, they argue, creates 'space for micro worlds to produce autonomous effects that may have unexpected influence over the structures that have been emerging' (*ibid*: 2). This thesis addresses some of these unpredictable and contingent outcomes in the specific context of the micro world of nurses at Bethesda. Thus, this wider health care context is the backdrop against which nurses are newly trying to position themselves, to reconfigure their role in

relation both to the earlier status associations of the profession and to new challenges in the post-apartheid context.

### **Consolidating the language of ‘rights’**

What is apparent from the implementation of the new management practice described above is the range of ideological tools used in its support. Represented by the ANC government as a necessary and economically imperative approach to health care delivery, these recent shifts are carried through with an ideology of pragmatism that, following the World Bank’s good governance strategies introduced first in the 1980s, place an emphasis upon ‘value for money’, efficiency and effective management as major priorities. Yet this approach potentially conceals a wide array of political implications. James Ferguson points out that such pragmatism is rooted in a global orthodoxy that he calls ‘scientific capitalism’, in which the market ‘denies its own status as a morality, presenting itself as mere technique’ (Ferguson 2006: 81). Thus various policies – specifically those propagated by the World Bank and the IMF – are justified with the language of economic rationalism that implicitly claims independence from any kind of moral order. A similar point is made by McLennan in the South African context; she calls for ‘an unmasking of the workings of apparently neutral or independent institutions to expose the politics that define delivery’ (McLennan 2007b: 6). She suggests that this ‘politics of delivery’ has come to replace a ‘politics of struggle’ that characterised the anti-apartheid era (McLennan 2007a). Framed around the pivotal moment of transition, this dichotomous way of representing the change does not, however, take into account the pervasive continuities with the past, and the extent to which the apartheid government itself deployed ‘cold, technocratic, economic reasoning’ (Ferguson 2006: 71) in fending off mass discontent around the inequitable and unfair distribution of state resources (Posel 1987; Breckenridge 2005).

Yet it comes as no surprise that the post-1994 ANC government has been at pains to separate itself ideologically from its predecessor. Hence a new set of ideological tools – in explicit opposition to apartheid – accompanies the embracing of neoliberal economic policy. A discourse of human rights, for example, is now a pervasive feature of the South African context. Wilson suggests that ‘human rights talk has become *the* central

language of nation-building in democratizing countries such as South Africa' (2002: 210). During the few years preceding the transfer of power to the ANC, human rights emerged as a counterpoint to apartheid's emphasis on group categories and so-called 'separate development'. The 1996 Bill of Rights and the institutions of the Constitutional Court and the Truth and Reconciliation Commission (TRC) consolidated the idea of rights as a defining political concept associated with post-apartheid transition and with the wider project of nation-building. The notion of rights, Wilson argues, enabled the effective politicisation of constitutionalism, linking it with a wider pan-Africanist and anti-apartheid struggle, and hence legitimising a new state project and set of legal institutions (ibid: 211). The idea of rights, therefore, has been essential in consolidating a perception of a distinct and redemptive break with the past: 'Where the previous state had been authoritarian, repressive and oligarchic in nature, the new state is intended to be democratic, developmental and committed to a culture of human rights' (Cameron & Tapscott 2000: 81).<sup>14</sup>

This discursive focus on the idea of rights as a way of uncovering the evils of apartheid is evident, more specifically, in the 'Submission on Nursing' to the TRC, by the Democratic Nursing Organisation of South Africa (DENOSA) in which it is stated that apartheid legislation 'constituted gross violations to the rights of nurses' (2007: 5). The document as a whole is oriented towards a vision of 'establishing a human rights culture in the health sector' (ibid: 4).

The discourse of human rights, therefore, has permeated the rhetoric of health care delivery. Another key example is the '*Batho Pele*' programme ('People First' in seSotho) – based on 'the right to access public services in an equitable, convenient and cost-effective manner'<sup>15</sup> as enshrined in the 1996 Constitution and Bill of Rights – marked a shift away from the treatment of patients as 'welfare recipients' and towards seeing them as 'customers' or 'clients'. It consists of a set of eight '*Batho Pele* principles' intended to guide managers and health care workers in correct practice, laying out an agenda for the reformulation of service delivery that would be oriented towards customer choice and would, in particular, enable patients to hold public

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<sup>14</sup> 'Rights' is not an exclusively post-apartheid concept in South Africa. During the resurgence of African nationalism in the 1940s, for example, the ANC adopted a rights-based discourse influenced by the post-World War II Atlantic Charter (Dubow 2005: 3). Nonetheless 'rights' has emerged as an overwhelming and pervasive public discourse in the post-apartheid years.

<sup>15</sup> See <http://www.dpsa.gov.za/batho-pele/history.asp>

servants accountable.<sup>16</sup> Thus, the politically charged notion of human rights is continually deployed in support of the wider economic strategies of the government vis-à-vis service delivery, in which increased emphasis upon performance management, accountability and commercialisation – all strategies implied in the *Batho Pele* programme and motivated by the GEAR-led priority of fiscal control – would ostensibly enable the reduction of expensive state administration. Ferguson suggests that ‘the moral premises [such as individual rights and private property] on which the technicizing justifications of structural adjustment depend almost always remain *implicit*’ (Ferguson 2006: 80, his emphasis). However, I would argue that in the South African context, the notion of ‘rights’ has become a widely evoked and *explicit* feature of state rhetoric, partly because of a heightened necessity to mark the transitional moment, and the intense need for a discourse of moral redemption provoked by the downfall of apartheid.

As Ferguson points out, in African contexts the economy is not often so easily detached from the moral order. Rather, he argues, these two are intimately intertwined, and ‘the social meaning of production and accumulation is widely interpreted in fundamentally moral terms’ (ibid: 71), often through the mediums of witchcraft and chiefly power. Hence the widespread images of bloodsucking are a vivid expression of the moral interconnectedness of individual accumulation of wealth and social relations. In contrast, José Casanova points out that in Europe, as religion was diverted to the private sphere, so too were conceptions of morality: ‘Politics and economics became literally “amoral” spheres, realms from which moral or religious considerations ought to be excluded’ (1994: 64). This led, he suggests, to the ‘impoverishment’ of the public. This process became heavily gendered: ‘Home is the sphere of love, expression, intimacy, subjectivity, sentimentality, emotions, irrationality, morality, spirituality, and religion’ (ibid: 64). Work, on the other hand, was the juridical and objective, male domain.

But in nursing in particular, and in South Africa even more so, boundaries between home and work, private and public, the moral and the “amoral”, the religious and the secular, are blurred and contested. Yet the tropes of liberal democracy have the effect of

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<sup>16</sup> The eight Batho Pele principles include ‘consultation’, ‘setting service standards’, ‘increasing access’, ‘ensuring courtesy’, ‘providing information’, ‘openness and transparency’, ‘redress’ and ‘value for money’. In KwaZulu-Natal, a further 3 principles have been added. These are ‘encouraging innovation and rewarding excellence’, ‘customer impact’ and ‘leadership and strategic direction’. It is revealing to note that in the descriptions corresponding to these latter three, the word ‘customer’ replaces that of ‘citizen’ (applicable in the eight core principles), indicating an explicit shift in emphasis towards a business model. See <http://www.kznhealth.gov.za/bathopele.htm>



reining in notions of the moral, and challenging the plurality that otherwise characterises the creations of moral personhood in this context. In Malawi, Harri Englund suggests, the dominant discourse of human rights enforces ‘a particular understanding of human dignity... by attributing legitimacy to specific moral notions... thereby defining the contours of what is not only acceptable but also *conceivable*’ (Englund 2000: 580). As a result, it is contested in various ways. So too in South Africa, and from the situational perspective of nurses at Bethesda Hospital, the ideological tools of liberal democracy – those of rights, bureaucracy, secularism and accountability – receive particular responses, produce certain kinds of actions, and are negotiated and critiqued in the course of ongoing moral debate. It is upon such processes that this thesis hopes to shed light.

### **Fieldwork and ethics**

For the most part, my fieldwork was an exploratory process, replete with accidental events and unexpected turns. Only in hindsight it is possible to grasp the extent to which good fortune as well as misguided judgement were so inevitably a part of the experience of ‘doing fieldwork’. As I passed through its trials and errors, changes both in field site and in thematic focus became integral to the project. Having set out from the beginning with an open and flexible approach, trying as far as possible to be guided by emerging data rather than by a pre-emptive, fixed agenda, I now look upon these changes – although I often experienced them as frustrating and nerve-wracking at the time – as fruitful and necessary aspects of the endeavour, enriching and adding nuance to the process of ethnographic research.

The events I describe here took place between October 2005 and October 2007. I set out originally to investigate the processes and experiences of nurse migration from South Africa to the UK, with a view to carrying out ‘multi-sited’ ethnography in both countries. I spent 6 months, following an arduous National Health Service (NHS) ethical clearance procedure, carrying out research amongst nurses working at Guys and St. Thomas’ NHS Trust in London. Following this, in June 2006, I began research at McCord Hospital in Durban. Over the course of 6 months there, I attended departmental meetings, carried out interviews with nurses and observed several consultations between nurses, doctors and patients. I joined the hospital choir, attended graduation ceremonies

and other formal occasions, and slowly developed a closer relationship with a small number of nurses, several of whom I visited in their homes in various townships in or near Durban. During this time, I became gradually acquainted with the wider health care infrastructure of KwaZulu-Natal, and visited several other hospitals both in Durban and in rural parts of the province. This included a trip to Bethesda Hospital in October 2006 with the Red Cross 'flying doctor' service that transports doctors from Durban to outlying rural areas once a month by aeroplane to carry out specialised treatment and consultation.

My interest in looking beyond the specific 'field site' of McCord stemmed from a desire to understand the hospital's place within a broader context but, more specifically, because an interest in migration inevitably takes one beyond particular locations to look at the movements between these and other locations and, indeed, to challenge the very assumption of boundedness implied by the concept of 'field site' (Marcus 1995). Most people I spoke to assumed that nurses trained in rural hospitals would use the city as a stepping stone into the global labour market. Yet this seemed not to be the case at Bethesda, from where a number of nurses had gone directly to the UK. In any case it became clear that, despite their geographical separation and distinctively different physical landscapes, the 'rural' and the 'urban' were mutually constituted, fused into each other through myriad chains of interactions, migrations and institutional connections. I moved to Bethesda Hospital in December 2006, staying there until October 2007 and ultimately making it the key focus of my thesis. Yet despite this eventual focus on one of the three hospitals, the earlier experiences and data gleaned from time spent at Guys & St. Thomas' and then at McCord Hospital undoubtedly enriched my understanding of, and exposure to, a wider health care context, and provided important sources of comparative reference throughout the writing process.

In order to do carry out research at Bethesda I needed to seek permission from the provincial Department of Health.<sup>17</sup> I embarked on a three month long process in the September prior to leaving Durban, beginning with the submission of a research proposal and ethical approval from my university. Finally, after two trips to Pietermaritzburg and many emails and phone calls, I received the letter confirming ethical approval and permission to do research at Bethesda. I produced this letter dozens

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<sup>17</sup> This process was considerably shorter at McCord because as a mission hospital, only partially controlled and funded by the state, it had its own, internal ethics procedure that was much easier and quicker to navigate.

of times during the course of field work, as formal and symbolic verification of my official role as a 'researcher'.

Ethnographic fieldwork unavoidably entails becoming part of the field site: ethnographers enter 'the field' not as detached observers, as Pottier shows, but as 'social actors endowed with an array of attributes and biases that influence the nature and outcome of their social inquiries' (Pottier 1997: 206). The point was made by Britan nearly 30 years beforehand in relation to ethnographic fieldwork in institutional settings, saying that 'once immersed in a bureaucracy, the anthropologist himself becomes a player in the political game' (Britan 1979: 217). During my own field work, I was not only a part of the research context but also took on a particular role within the bureaucratic culture of the hospital. This meant that my interactions with others were affected by a range of assumptions and expectations about me, that were associated with my status not as an 'outsider' but rather as a specific kind of 'insider'.

As I began the research at Bethesda, I quickly came to realise that my initial encounter with South African state bureaucracy represented only one of what David Mosse has called 'effective mechanisms for filtering and regulating the flow of information and stabilising representations' (Mosse 2005: 12). During my interactions with nurses and other employees at Bethesda – a process with which I had begun already to gain familiarity in the previous two hospitals – I came to realise that techniques for concealing certain opinions and for selectively disclosing information were integral features of bureaucratic discourse, and that my own status as a 'researcher' – a 'local category' within this culture of bureaucracy - forged conceptual and ethical limitations for my own research.

For nurses, the category of 'research' is a familiar one and most have undergone at least some basic training in research techniques and methodology during their nursing education. Some of the more senior nurses had carried out research projects themselves, and had a clear opinion about the procedures and processes that research entailed. During basic nursing training, students are taught how to carry out research in terms of a set of stages, including the initial generation of a hypothesis relating to some specific aspect of patient care or hospital procedure. For this reason nurses were often surprised that my own research was not built around a single hypothesis that I was attempting to prove or disprove, although I would try to explain that I generated hypotheses in the

process of and in response to, as well as prior to, data collection. This attitude was perhaps partly due to the style of education that nurses received. I realised this whilst teaching a research methodology class to students at the nursing college at Bethesda during my time there, which informed me about the syllabus as well as the type of teaching and education that students had come to expect. Most noticeable was that the syllabus taught only a single set of methodological techniques, in the form of one procedure for carrying out research that involved the systematic completion of prescribed stages. The syllabus at this basic level therefore encouraged students to envisage a single 'correct' way of doing research that was fairly narrow, hence their unfamiliarity with and suspicion of techniques that fell outside of this definition.

Almost nobody with whom I spoke had heard of 'ethnography' or 'participant observation', and nurses were often deeply suspicious of activities, questions, or interactions that fell outside of the parameters within which the procedures and aims of 'research' were deemed to lie. So for example, a prearranged interview seemed to sit comfortably within this paradigm, whereas spending time on the wards was possible only several months after my arrival, when people knew me better and I had established a relationship of trust with particular individuals. Visiting nurses in their homes generally required an even closer degree of trust and friendship. I tended to find myself, particularly at the beginning of research, conforming to the parameters of these expectations. I would carry out a certain number of interviews regularly for example, in order to legitimately fulfil my role as 'researcher' at the hospital. At the same time, and with a small number of people that I began to get to know, I had to try to reshape my role, to disentangle my association with familiar types of research, and to become an 'outsider' – in the sense of carrying out a type of research that did not fit easily with local categories – in order to move out of the interview context and to establish a broader methodological base for the research, a task I feel I achieved with only partial success.

A second assumption held by nurses about 'research' was that its purpose is, or certainly should be, applied: to investigate the implementation of procedures or problems arising in health care delivery in order specifically to inform policy and to improve standards. This ethical imperative that defines research aims in a medical context served as an ongoing source of pressure that shaped and influenced my research focus in various ways. Research that was not seen as *directly* relevant and practical was

sometimes – perhaps understandably – approached with indifference and a general lack of tolerance. It is this type of sentiment amongst staff that makes it, as Mosse suggests in relation to a development setting, ‘virtually impossible to sustain long-term participant observation in the absence of making a practical contribution’ (Mosse 2005: 12). The usefulness (or not) of anthropology and how it might be applied in practical ways is an ongoing debate (Pottier 1993; Rylko-Bauer *et al.* 2008). It is an issue that I feel is particularly acute in a medical setting.

This was a conundrum during field work, and was relieved in part, by small voluntary contributions that I sought to make throughout, such as teaching the research methodology and sociology course in the nursing college, computerizing patient files in the HIV/Aids clinic, assisting in the nursing school library, and performing a number of other minor administrative tasks. This helped to establish a feeling of reciprocity that I think was appreciated by nurses and management on the whole, as well as – for those for whom research was a relatively invisible pursuit – giving me an alternative and additional ‘role’ within the hospital. The different types of voluntary work also provided vital opportunities to observe hospital activities from a variety of positions.

In addition to this ethical concern, a second issue arose from the assumption that research necessarily leads into policy and service improvement: it has come to be viewed as a type of ‘audit’, a mechanism by which employees are monitored and assessed, and information about them passed to management. This implicit assumption about my role as ‘auditor’ in the hospital substantially affected my relationship with some nurses and the degree of access I was granted to certain types of information. In this sense I was seen to occupy a role within the broader culture of surveillance and accountability; nurses occasionally expressed an intense fear of ‘getting into trouble’ that, at times, made it difficult to talk with them at all.

At other times, nurses indicated their cautious approach to the disclosure of information by the choice of language they adopted, perhaps concealing certain views and opinions behind hospital jargon. The following statement, taken from an interview with a senior nursing matron, illustrates this point. I asked her what changes had taken place in nursing since she began and she replied:

Care is deteriorating. The level of care is getting down for the same reasons that people don’t take patients as their first consideration. [long pause]. Although, there

*are* rules and regulations, the standards that needs to be met. That helps to improve the standard of care. Policies and procedures, they are really helping a lot. And these things, the quality improvement projects that are implemented, they are helping a lot in ensuring that quality of care is improved.

This short statement expresses two opposing views, the first that ‘care is deteriorating’ and then, in contrast, that ‘quality of care is improved’. This apparent shift of opinion reflects a tendency amongst hospital staff to move between different types of institutional and personal explanations in support of certain claims. These short sentences include several generic concepts that are associated with the formal bureaucratic procedures of the hospital, and that take on particular meanings within the institutional context. These include ‘rules and regulations’, ‘standard of care’, ‘policies and procedures’, and ‘quality improvement projects’. Endorsing these concepts in the interview was a way of confirming that the implementation of policy – the hospital’s central, official aim – was effective. It is evident from the contradiction contained within the statement that it would be misleading to interpret it as a kind of ‘true’ reflection of belief or opinion. Her comments are understandable in relation to the fact that as a senior matron, and in an interview context, she felt in part responsible to portray the hospital in a positive light.

In this sense, nurses adopt a discursive form that is a normalised aspect of institutional rhetoric and which they are able easily to articulate after years of working for the hospital and being ‘encultured’ into its dominant discourses (Spradley 1979). Yet, as this thesis sets out to demonstrate, institutional discourse is not something that is imposed from ‘above’, but is generated through social practice (cf. Long 1992). In this sense, institutional rhetoric is not passively adopted by nurses, but rather, nurses and other frontline workers at the hospital are involved in reproducing it in various social contexts including interviews, and demonstrate moreover their ability to move verbally from one sphere of knowledge to another. Thus, nurses are participating actively in creating institutional discourse as a form of social reality. As Strathern has made clear, ‘people are managing what is to be known, and to whom when’ (Strathern 1999: 13). Any statement can only, therefore, be understood ‘in the context of its production’ (ibid: 7).

As I stumbled through the earlier phases of fieldwork, I found this frustrating and I could not help but feel that there was a ‘truth’ to be uncovered underneath the rhetoric. Yet, although I experienced them initially as methodological problems, these difficulties

can also be seen as an example of one type of bureaucratic process unfolding. What became apparent, then, was that the research process itself reveals, and is itself constitutive of, the various discourses of bureaucratic culture at the hospital. So too, the ethnographic text must be looked upon as another kind of document that is produced in, and not external to, the hospital setting (cf. Riles 2006). As Burawoy succinctly stated it: ‘We are engaged in a reflexive science in which the limitations of method become the critique of society’ (Burawoy 2000: 28).

### **Situating Bethesda Hospital**

Bethesda Hospital is located at the top of one of the southernmost mountains of the Lebombo mountain range, and behind it looks out across the lowveld, a large plane stretching as far as the Indian Ocean to the east, just visible on a clear day. It is located in the village of Ubombo, 18 kilometres from the town of Mkuze that lies at the foothill of the mountain. Despite the rather remote, rural impression one gains as one travels up the densely covered mountainside, the hospital is well-connected to KwaZulu-Natal’s major transport infrastructure, with the national N2 road running through Mkuze, reaching the town of Pongola and continuing into the province of Mpumalanga to the north, while to the south it follows the coastline through the large urban centres of Richards Bay and Empangeni until it eventually enters the city of Durban some 350 kilometres away. To the northwest of Ubombo, beyond the large Jozini dam, lies the national border between South Africa and Swaziland, and due north of Ubombo, further still, is situated South Africa’s border with Mozambique. Its location near to these various borders (as well as its position within a changing political geography given the historical turbulence of the region) has meant that this area has been a place of considerable flux and contestation.

The road that winds its way up the mountainside from Mkuze, rebuilt with tarmac less than ten years ago, reaches the hospital on its right hand side after a sharp bend to the left and then the police station and magistrates court at the mountain’s peak, just before the tarmac reaches an abrupt end, and the dusty road continues along and back down the other side of the mountain into the lowveld. The conspicuously unfinished road is a symbolic reminder of the incomplete state of service delivery in post-apartheid South

Africa, exaggerated by local hearsay claiming that the money allocated for the completion of the road was stolen by a government bureaucrat.

The space and physical size of the hospital gives it a dominating visual presence in an otherwise sparse rural landscape. It is by far the largest complex of buildings in Ubombo, spread over an area approximately 500m by 200m, and is separated from its surroundings by a tall perimeter fence. The hospital's developed infrastructure of solid, brick buildings and of electricity and water supplies distinguishes it from the surrounding area. On the frequent occasion of electricity black-outs, usually coinciding with heavy rains, the hospital's own internal reserve generator is automatically switched on and can be heard at some distance from the hospital. These visible and audible imprints on the landscape indicate a significant concentration of resources within the hospital's fences, set apart from an area otherwise devoid of such features. I return to this symbolic spatial order in Chapter 3.

Opposite the hospital is a row of several shops, including a general food and clothes stall and a bar, outside which are always several men sitting and drinking beer, whilst others mill around waiting for the buses and mini-bus taxis that shuttle people up and down the mountainside. An expensive bed-and-breakfast next door, set back behind trees and out of view, attracts a steady trickle of tourists to the area. On the hospital's side, lining its tall wire fence, is a row of smaller stands where people sell bunches of fruit and vegetables. The court and police station are nestled in an area known locally as 'white city' which, as its colloquial name suggests, is where government clerks, magistrates, hospital employees and European missionaries have lived for decades, positioned here at the mountain's peak to escape malaria which – prior to government spraying programmes – was prevalent in the lower regions. Situated here, too, are a number of different churches. Several church bodies and denominations are active in the area, notably Zionist, Lutheran, Roman Catholic, Anglican and Methodist. The small Methodist mission, situated near to the police station, has close historical links with the hospital which was set up and run by the Methodist Church of South Africa for 45 years.

Behind this stretch of road, and the cluster of buildings and institutions that make up the village of Ubombo, homesteads are spread scarcely over the mountainside in all directions. Although there is quite considerable variability of living standards in the



region, overall it is characterised by high levels of poverty, unemployment and poor utility and road infrastructure. These are a reflection, in the main, of years of relocation and agricultural degradation under successive colonial and segregationist governments and, later, of the high-apartheid policies of the KwaZulu ‘homeland’. In the early 1990s, the area suffered a wave of violence that swept through the cities and countryside of KwaZulu during the resurgence of Zulu ethnic nationalism, led by the Inkatha Freedom Party (IFP), that overwhelmed the political and social landscape of this recent period. The violence was, however, according to some local accounts, less severe and more intermittent than in other areas, given the strength of IFP presence and support in this region.

Ubombo and its surrounding area have undergone considerable and ongoing political change. A magistracy was first established in Ubombo in 1892, just prior to when the area – known to the British as ‘Amatongaland’ – was put under British Protection, prior to its annexation to Zululand.<sup>18</sup> In 1927 it was constituted as a full magistracy and transferred to the control of the Department of Native Affairs.<sup>19</sup> The name ‘Ubombo’, which then referred to an administrative area, is now used colloquially to denote this region. Much of this area later formed part of the KwaZulu bantustan, one of the nominally semi-independent ‘homelands’ set up by the apartheid government, between 1970 and 1994. As such, from April 1972, the Magistracy became an office of the KwaZulu government service, with Ubombo and Bethesda Hospital just inside the then newly demarcated bantustan boundary. The creation of ‘homelands’ was a policy of the

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<sup>18</sup> From the thirteenth century until the late nineteenth century this area is thought to have been politically dominated by a Tsonga speaking people known as the Thonga. This region, between Maputo in the north and Lake St Lucia in the south was thus latterly referred to as ‘Thongaland’. In the late eighteenth century, the Zulu polity started to form and by 1824, had become the dominant political force in the region. ‘British Amatongaland’ (also referred to as ‘Maputaland’) was the name given to the southern part of the area when Thongaland was divided between the British and Portuguese in 1875, creating a boundary that was later to mark the border between South Africa and Mozambique. ‘Amatongaland’ denoted the territory north of the Mkuze river, in between the Lebombo mountains to the west and the Indian ocean to the east. In 1879 the British defeated the Zulu and the area known as ‘Zululand’, to the south of Amatongaland, was annexed to the British in 1887. Zululand existed formerly from 1887 to 1897 as a British colony. In 1895 Britain established a ‘Thongaland Protectorate’. Both Zululand and Amatongaland were annexed to Natal in 1897, after which the name ‘Zululand’ referred colloquially to the area north of the Tugela river. Amatongaland is more commonly referred to as ‘Maputaland’. From 1910 until 1994, the whole area from south of Durban to Zululand and Maputaland in the north, known as ‘Natal’, was one of four provinces in South Africa. In 1970, the Bantustan of ‘KwaZulu’ was formed out of various and separate pieces of territory including parts of Zululand and Maputaland, and was granted self-governing status in 1976. In 1994, the present-day province of ‘KwaZulu-Natal’ was formed when the boundaries were once again redrawn (see Map 1). The area has, therefore, been a site of immense political and cultural flux and contestation (Webster 1991; Harries 1993; Kloppers 2005).

<sup>19</sup> This information was gleaned from a file kept at the Ubombo magistrate’s office that contains various pieces of historical, geographical and political information about the region, recorded by successive local magistrates and officials of the department. Thanks to Chief Magistrate Mr V.Z. Mkhwanazi for kindly permitting access to this document.

apartheid state intended, in part, to generate legitimacy for itself by claiming to support ethnic political self-determination, despite the severe levels of underdevelopment and poverty that were perpetuated under successive 'homeland' policies. During this period, Zulu ethnic identity emerged as a major social and political force, and the KwaZulu bantustan became the site for a resurgence of ethnic nationalism led by Chief Mangosuthu Buthelezi of the Inkatha Freedom Party (IFP) who established a powerful grip over the region (Maré & Hamilton 1987; Harries 1993).<sup>20</sup>

Part of the government agenda, at least in rhetoric, entailed supporting and funding institutions of welfare and industry that would enable the 'homelands' to develop self-sufficiency. The government began its takeover of hospitals in these areas in 1973, mostly with the assent of the missions because of the severe financial difficulties they faced. Bethesda Hospital was taken over by the government in 1982 and transferred to the control of the KwaZulu 'homeland' government, a process which I describe in detail in the next chapter. It was later reintegrated within the national health care infrastructure following the inception of post-apartheid democracy and the dissolution of the bantustans. At this time, the newly formed province of KwaZulu-Natal was re-divided into eleven municipal districts (see Map 2). Bethesda Hospital now falls under the district municipality of Umkhanyakude ('distant light'), and within that, the local municipality of Jozini. A further four hospitals are located in the district of Umkhanyakude, all similarly former mission hospitals (see Map 3).

Today, Bethesda is a small district hospital serving a population of over 90,000 people who are scattered throughout the 1500km<sup>2</sup> catchment area.<sup>21</sup> It is a 240 bed hospital, providing the whole range of district level services, and operating a referral system to other hospitals for more specialised consultations and treatment.<sup>22</sup> It also coordinates a network of eight primary health care clinics spread throughout the region, and two mobile clinics. With a nursing staff of 150, there is currently a 34 per cent vacancy rate

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<sup>20</sup> Given the profound influence of these recent historical processes, people living in the Ubombo area now largely identify themselves as 'Zulu'. But until recently this has been a site of fluctuating ethnic allegiance and contestation, given the historical prevalence of Tsonga speaking people and the oscillating political control of Thonga and Zulu polities. As such ethnic categories were not as clearly demarcated as they currently appear to be (Webster 1991; Felgate 1982; Vail 1989; Hamilton 1995).

<sup>21</sup> Public hospitals in South Africa are categorized by three levels – District, Regional and Tertiary - according to their size and the number of services and specialities offered.

<sup>22</sup> These services include Trauma and Emergency, Medicine, Obstetrics & Gynaecology, Paediatrics, Dental/Oral Health Services, Mental Health, Medical Social Work, Eye care & Cataract case finding, Rehabilitation Services including Physiotherapy & Occupational Therapy, Dietetic Services, Clinical Support Services including Laboratory services, X-ray services & Ultrasound.

amongst this group. The hospital as a whole is running at roughly 60 per cent of its capacity due to staff shortage.<sup>23</sup> The shortage is most severe at the specialist and professional levels, although it also affects other nursing categories<sup>24</sup> (see Appendix A for health care indicators for the Umkhanyakude District Municipality).

## **Thesis scope and layout**

The thesis, overall, is concerned with the reconfiguration of status and professionalism – and processes of moral self-fashioning – amongst nurses within the medical setting and within a wider social and political context of post-apartheid South Africa. Specifically, it provides an historical-ethnographic account of the views and activities of nurses working in a rural government hospital in northern KwaZulu-Natal, looking particularly at how nurses respond to, and negotiate their positions in relation to, changes in health care management and the wider debates of post-apartheid public discourse. Therefore, the thesis necessarily entails an engagement with different scales, both temporal and spatial. Whilst taking into account the varying and often seemingly hegemonic influences of wider processes and structures, I argue that these are nonetheless contingent upon local circumstances, and may be taken up, resisted, or used, in very different ways. One underlying purpose of the thesis is to show, as Burawoy has claimed, that ‘the grip of forces beyond our control... turn out to be quite fluid and susceptible to influence’ (2000: 27). The thesis is focused upon the particular locale of an institutional workplace but is not confined to this; it is concerned fundamentally with the relationship of that workplace to a wider set of regional, national and global processes.

Chapter 2 introduces the ethnographic location of Bethesda Hospital, and provides an historical account from its inception in 1937 as a mission hospital of the Methodist

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<sup>23</sup> See ‘Bethesda Hospital Strategy Plan 2006 – 2008/9’.

<sup>24</sup> There are several categories that constitute the nursing hierarchy. In order of the most senior to the most junior positions, these are as follows: ‘Nursing Manager’, ‘Deputy Nursing Manager’, ‘Assistant Nursing Manager’, ‘Chief Professional Nurse’, ‘Senior Professional Nurse’, ‘Professional Nurse’ (also referred to as ‘Registered Nurse’), ‘Enrolled Nurse’ (also referred to as ‘Staff Nurse’) and ‘Enrolled Nursing Assistant’ (See the hospital organogram in Appendix B). Nursing Managers are frequently referred to with their former title of ‘Matron’. I use this term in the thesis because of its current colloquial usage. I also use the term ‘Sister’ – the former title for professional nurses – for the same reason. Further explanation of the qualifications and duties associated with different nursing categories is given in Chapter 5.

Church of South Africa, drawing primarily on archival data of hospital and government records, as well as on some nurses' written autobiographical accounts, and oral data collected from nurses and doctors.<sup>25</sup> Founded by Edinburgh-trained doctor Robert Turner in 1937, the hospital was run by the missionary society of the Methodist Church of South Africa until its takeover by the government 45 years later in 1982. The chapter describes how this small mission hospital, founded upon a very specific set of religious ideas, was quickly drawn into a wider apartheid system of health care and labour control that was increasingly incompatible with the missionary vision of health care. Yet, in the hospital's final years under Methodist control, missionaries drew on a broader, international shift of rhetoric towards primary health care, enabling a reinvigoration of the original aims and ideologies of the mission even as imminent government takeover loomed large. Advancements were made in the area of primary health care while the hospital was under the control of the KwaZulu 'homeland' government (and still being run locally by mission doctors) between the years of 1982 and 1994, even though the period was characterised by massive inequity in the redistribution of apartheid government funds and a continuing deterioration of health in the bantustans. This account, therefore, describes a changing micro-struggle for power over a single hospital in the context of a wider political economy of health care, and the effects of this struggle on service delivery in the region. It considers both the institutional dynamics that influenced the hospital's development and the religious basis of medicine and nursing, and shows how these impacted upon the development of health care and nursing at Bethesda.

Chapter 3 introduces the contemporary context but, in keeping with the previous chapter, maintains a broad scope by looking at the position of nurses in relation to a wider sphere of social relations in and around the community in which the hospital is situated. Through accounts given by individual nurses and patients, I return to some well-rehearsed themes about nurses in South Africa that express their apparently ambivalent relationships with their patients. Nurses appear, at different points in the literature, both as sympathetic and compassionate 'culture-brokers' (Digby & Sweet 2002) and as upwardly-aspiring professionals seeking to distance themselves from the

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<sup>25</sup> Archival data includes hospital reports, minutes of board meetings, letters, Methodist Church pamphlets, newspaper articles and newsletters collected at the Methodist Archives Collection at the Cory Library for Historical Research in Grahamstown and the National Archives in Pretoria. Further material was held by Dr Daryl Hackland and Dr Steven Knight. Many thanks to them for allowing access to these documents.

wider social context of which they are part. Using this tension as a point of departure, the chapter looks not only at nurses in their professional relationship to patients in the hospital context, but at their ambiguous roles as ‘public servants’ and ‘private citizens’ (Gupta 1995) in a wider external sphere. The ethnographic terrain of this chapter stretches, therefore, beyond the locus of the hospital to include the nearby village of Nkangala, where a number of nurses are resident. What emerges is a highly contingent and fluctuating set of claims associated with nurses’ perceived status and self-image. Ideas of status and professionalism are strands that, albeit in contingent and diverse ways, run through all the narratives presented.

At this point, the ethnographic lens zooms in on the workplace itself, the following two chapters both dealing with the internal dynamics of Bethesda Hospital. In Chapter 4, I consider ways in which nurses’ memories of the hospital’s missionary past are constructed and creatively deployed in the contemporary production of moral discourses relating to work. This discussion is foregrounded (as is the thesis as a whole), by the profound feelings of moral and professional discomfort and sense of chaos felt by nurses, generated by the severity of ill-health in the region, and the subsequent enormous workload they and other health workers take on. In a context of intense bureaucratic pressure on health care institutions and individual employees to meet the growing demands placed upon them, I argue that senior nurses’ association with an idealised missionary past enables them to forge an elite category of professionalism from which their junior counterparts are excluded. Furthermore, the notion of ‘rights’ is drawn upon negatively, in its association with a contemporary ‘secular’ period. In this sense, a hierarchical relationship between senior and junior nurses – driven by a preoccupation with professional status that has historically characterised the nursing profession in South Africa and globally – meshes with debates around the contemporary perceived crisis in health care, thus taking on new meanings that are infused with heightened moral concern. An ongoing social commentary about the relationship of the hospital to its missionary past and a perceived ‘secularization’ of the institution plays heavily, therefore, into contemporary issues concerning workplace hierarchy, status and morality.

Part of the pressure upon nurses generated in the current context has to do with the emergence of an international public sector ethos of ‘accountability’. In Chapter 5, I

look at how discourses of accountability take shape in the ward context, and how these affect the behaviour of nurses at work. One seeming contradiction that became quickly apparent to me was that although nurses evidently experienced an intense fear of being held culpable for mistakes carried out on the ward or for incomplete work, they nevertheless responded to this, at times, with the prioritising of administrative tasks over patient care. I consider how the emergence of managerialism as a central tenet of health care delivery – and a subsequent shift in accountability mechanisms towards an emphasis upon a separate managerial department largely absent from the daily working context of the wards – alters the behaviour of nurses who respond to these new channels as effectively as they can. This style of managerialism emerged initially in the 1980s, but was later embraced and fully established by the ANC. My intention here is to show the ways in which the wider tropes of liberal democracy that pervade public moral discourse in post-apartheid South Africa are taken up and negotiated in a variety of ways in one particular workplace setting, affecting behaviour in a manner not necessarily intended. Thus I pose the question of how the normative values of ‘rights’ and ‘accountability’ translate unpredictably into practice, reinforcing workplace competition even as their ideological underpinnings purport to have a levelling-out influence upon a previously taken-for-granted hierarchy between patients, nurses and doctors.

The final part of the thesis reflects upon the themes of professional aspiration, workplace competition, and perceived moral disintegration developed thus far, by exploring some ways in which nurses generate a mutual sense of purpose and control, while at the same time pursuing embattled struggles for status and self-recognition, through the practices of Born-again Christianity (Chapter 6) and international migration (Chapter 7). Whilst earlier sections of the thesis deal with the historical trajectory of the hospital and with idealised notions of the past, these final chapters – although concerned with current practices – emphasise nurses’ hopes and aspirations that are projected into an imagined future. Thus, in Chapter 6, contributing to a growing literature on the emergence of Pentecostal Christianity across Africa, I suggest that the success of a Born-again prayer group at the hospital belies the notion of a secularised institutional context. I show how, through communal prayer and worship, nurses grapple with workplace problems, whilst at the same time, reinforcing the basis of these in minute and subtle ways.

The final chapter shows how migration offers new and powerful forms of status acquisition in the post-apartheid context. A focus on the specific career strategy of migration enables a vantage point from which to consider the gendered dynamics between men and women in the domestic situation. What becomes apparent is that such power relations intercept women's career strategies, differently and sometimes contradictorily. On the one hand, women are constrained to act in particular ways by the assumptions and expectations implied in their gendered roles; the choice of nurses to migrate or to return home is often heavily influenced by the behaviour or expectations of men. On the other hand, the financial and emotional independence enabled in part by their economic status, and expressed in some instances by their migration to England, enables them to negotiate, reconstitute and sometimes even to bypass, these patriarchal expectations.<sup>26</sup>

A focus on international migration entails a consideration not only of the homogenizing effects of transnational capitalism on patterns of migration globally, but also the particularities of economic policies and state intervention, and the historical implications of labour migration in this region, all of which mediate social and domestic relationships in particular ways. Therefore, this final chapter links, once again, into a much wider historical and spatial frame with which the thesis began. My intention in doing so is to highlight the myriad and complex factors, invisible in the immediate ethnographic situation, that influence the opportunities and obstacles faced by nurses.

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<sup>26</sup> The focus in this chapter is mainly upon female nurses. Some male nursing voices are heard in this thesis, but the experience of nurses working as men within the profession is not something I have focused upon, and is a topic that requires further research. Some recent studies have begun to examine the role of male nurses in South Africa which had, until then, been largely neglected (Burns 1998; Marks 2002).

## Chapter 2

### A history of Bethesda Hospital

Here is Africa – backward, content, dark and ridden by the power of the witchdoctor. His baleful influence is ever at work, and instances continually occur to make one shudder with horror. In such circumstances it is good news to report that through the generosity of Lord Maclay there is a possibility of a Medical Mission being established at Ubombo.

- H.S. Robinson, Secretary of the Maputaland Mission, January 1938<sup>27</sup>

#### Introduction

These words, echoing long-established missionary sentiments, document the beginning of Bethesda Hospital which was to be formally opened in 1940. The original idea for a hospital in Maputaland came from a mission doctor, George Gale, then working at Tugela Ferry Mission Hospital at Msinga in Natal. He appealed to Scottish philanthropist Lord Maclay, who agreed to provide the initial costs for a hospital at Gale's chosen site of Ubombo.<sup>28</sup> The Methodist Church decided to take on the project, to which both Gale and Maclay agreed, and Gale recommended Edinburgh-trained mission doctor, Robert Turner, to begin the project. After meeting Lord Maclay and receiving his approval, Turner took up the post of District Surgeon in the village of Ubombo in October of 1937, in order to provide some financial assistance to the mission (Gelfand 1984: 214-5).

When Turner arrived with his wife Lena – a trained nurse – and their two young daughters, to take up his post, following an arduous three day journey from Durban, the local magistrate showed them to the only available accommodation in this mountaintop

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<sup>27</sup> See 'The Fifty-Sixth Annual Report of the Missionary Society of the Methodist Church of South Africa', January 1938. CLHR Methodist Pamphlet Box 2.

<sup>28</sup> Lord Maclay's financial contribution to mission hospitals extended well beyond Bethesda Hospital. On a return to Scotland from a visit to South Africa in 1925, Dr Donald Fraser of the United Free Church of Scotland put out an appeal for funds for the Foreign Mission Committee of the church in order to support missions in Southern Africa. Responding to this appeal in October 1926, Lord Maclay offered £15,000 to support the placement of six doctors in Hospitals across South Africa (Gelfand 1984: 82). Tugela Ferry was one beneficiary, and was rejuvenated by the arrival of George Gale in September 1928 (ibid: 133). George Gale, who worked at Tugela Ferry from 1928 until 1936, was to become an extremely influential and progressive figure in health care in South Africa during the 1940s, assuming the post of Chief Medical Officer and Secretary of Health in 1946.



village: a 'shack' of two rooms, 'running with rats and cockroaches'.<sup>29</sup> A nearby sweet potato field on six and a half acres of government owned land was soon to become the site of a new hospital. Lord Maclay donated £2,500 towards the initial building costs, and the project was taken on by the Zululand and Maputaland Missions of the South African Methodist Church.

Bethesda emerged in the context of an already well-established field of missions in which several denominations were active. Methodists began their missionary work in the area at the turn of the twentieth-century (Whiteside 1906: 397), and started medical work several years later with a small clinic based at the Threlfall mission in Kosi Bay in 1930, followed by Bethesda in 1937 and Manguzi in 1947 (Gelfand 1984: 25).<sup>30</sup> This chapter includes, where relevant, a discussion of Manguzi Hospital, due to its close relationship with Bethesda Hospital throughout the period of mission control. Both were controlled by the board of the Zululand and Maputaland Mission of the Methodist Church of South Africa, and later in 1970 formed two hospital boards independent from the wider mission but integrated with each other through shared meetings and many members sitting on both boards.<sup>31</sup> Other missions were involved in medical work in this area at around the same time, most notably Mseleni Hospital, begun in 1914 by the South African General Mission (*ibid.*: 218), Mosvold Mission Hospital founded in 1936 by the Scandinavian Alliance Mission, a branch of the Lutheran group (*ibid.*: 206), and Hlabisa Lutheran Hospital, begun as a dispensary in 1923 (*ibid.*: 133). Mission activity in the area was, overall, prolific. By the mid-1970s, Helen Sweet notes, 'Natal and Zululand together had the highest concentration of mission hospitals in South Africa' (Sweet, forthcoming: 13).

This chapter deals with the history of Bethesda Hospital since its inception in 1937, drawing primarily on hospital reports and the minutes of board meetings, in addition to some written and oral accounts by individuals. I describe how this small mission hospital, set up by the Methodist Church of South Africa and thus with a very specific

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<sup>29</sup> Lena Turner. Unpublished autobiographical account. Thanks to Daryl Hackland for lending this document.

<sup>30</sup> Mission enterprise and white settler agriculture penetrated Zululand predominantly following the annexation of Zululand in 1887, later than it did the rest of Natal due to the dominance of Zulu traditionalist authority in the area (La Hausse de Lalouvière 2000: 10). An extensive literature describes the emergence of '*amakholwa*' ('Christians') throughout Natal and Zululand and their increasing association with 'respectable' and 'Western' lifestyles (e.g. Hausse de Lalouvière 2000; Etherington 1989).

<sup>31</sup> Minutes, Manguzi Hospital Board meeting. 24<sup>th</sup> Nov 1970. CLHR. MS 19 099.

set of ideas about its purpose and aims, was quickly drawn into a wider government system of health care and labour control that was increasingly incompatible with the missionary vision. Yet, in the hospital's final years under Methodist control, missionaries drew on a broader, international shift of rhetoric towards that of primary health care, enabling a reinvigoration of the original aims and ideologies of the mission, even as imminent state takeover loomed.

The government began taking control of mission hospitals in 1973 as the demand for health care increased along with the cost of its provision, a financial burden the missions could no longer sustain. Bethesda Hospital was taken over in 1982 and handed it to the control of the KwaZulu 'homeland' government, who formally ran it until the re-integration of the bantustans and the restructuring of the health system following the democratic elections of 1994. During this period from 1982 until 1994, then, the hospital was officially under the authority of the KwaZulu 'homeland' government. Despite receiving all its funding from the central apartheid government, the 'homeland' government nevertheless had legislative control over health care in KwaZulu during this period. The hospital itself was still managed and administered on site by mission doctors, and the Methodist mission maintained considerable involvement in its work. The transition from mission to state control was therefore felt as a gradual process, rather than an abrupt change. If anything, the 1994 transition brought about more significant and rapid changes than the 1982 takeover, given the radical restructuring of health services that took place.

This account, therefore, describes a changing micro-struggle for power over a single hospital in the context of a wider political economy of health care, and the effects of this struggle on service delivery in the area now known as the Umkhanyakude district of northern KwaZulu-Natal. The chapter tells three interlinking stories that provide an important historical and thematic backdrop to the thesis as a whole.

Firstly, I consider the simultaneous development of mission medicine alongside that of state bureaucracy, showing how the style of administration shifted from one of paternalism and piecemeal control in rural areas during the segregationist era prior to 1948, to a more bureaucratically rigorous and iron-fisted approach under apartheid. The 1940s was a significant period in the history of health care in South Africa, when a group of progressive doctors and members of government attempted to initiate a

programme of radical reform, shifting the country's health care system towards a model of community-oriented social medicine. The debates marked a period of considerable tension between different levels of government. For whilst provincial authorities struggled to fund the increasing hospitalisation of Africans in urban areas – a problem that provided the initial impetus for health care restructuring – they became reluctant to give up control of hospitals to the central government that was recommended as part of the radical proposals of the National Health Services Commission in 1944. The proponents of the report faced further resistance from members of the medical profession who feared being undercut by the proposed health centres. They were unable to follow through, therefore, with many of their more radical plans for reform. Nonetheless, the impact of their work was significant, both at the time – with the setting up of health clinics across the country – and in years to come as the international health care community shifted towards a primary health care agenda in the 1970s and 80s. I consider developments at Bethesda in relation to these wider debates and tensions unfolding nationally. The later transfer of power from mission to 'homeland' control in 1982, whilst strongly politically motivated, was bureaucratically disorganised and fragmented. This discussion of state involvement in health care delivery lays the ground for considering to what extent features of current bureaucratic and managerial practice at Bethesda find their roots in this earlier history or, alternatively, to what extent they owe their existence specifically to post-apartheid restructuring and an increasing international influence.

Secondly, I describe mission 'culture' and how this was experienced by nurses. Crucial to this was the political outlook of the missionaries and how this changed alongside the emergence, firstly, of a more severe apartheid regime and, later, of Zulu nationalism with the rise of Inkatha and the formation of the KwaZulu 'homeland'. This foregrounds a discussion, in Chapter 4, about the nostalgia felt by nurses for an idealised missionary past, and how this feeds into contemporary experiences of the workplace.

Finally, I describe the resurgence of missionary fervour in the years leading up to government takeover, and the way in which a new international model of primary health care was embraced by missionary nurses and doctors. I show that, despite the massive inequities inherent in the system of 'homelands' and in the health care system as a whole in South Africa during that period, the influence that mission doctors had over

the KwaZulu government in the years prior to democratic elections in 1994 enabled them to establish a network of clinics that constitutes the backbone of Bethesda's current primary health care infrastructure, in the context of a wider renewal of community oriented health care across the country. I show how an emphasis on primary health care emerged out of a longer trajectory, both within South Africa and internationally.

### **A dubious dependence: the relationship between mission and state at Bethesda**

When Robert Turner began his medical work in Ubombo, his wife Lena, herself a trained nurse, was his only assistant. They soon employed an African nurse, trained at McCord Mission Hospital in Durban.<sup>32</sup> By 1940, the hospital consisted of one 14-bed ward, 3 rondavels, 6 cubicles, an operating theatre and the doctor's house (Gelfand 1984: 214). Bethesda was opened officially on 4<sup>th</sup> July, 1940 with a 'Service of Dedication' carried out by Rev. Wilkinson, President of the Methodist Conference, and an opening ceremony performed by Mr H.C. Lugg, the Chief Native Commissioner who, during his speech, expressed 'the deep and practical interest of his Department in the plans of the Church for medical missionary work'.<sup>33</sup> As this quote suggests, the presence of Mr Lugg was not simply ceremonial, but marked the beginning of a close involvement of the government with Bethesda Hospital.

At the hospital's inception, mission ideology seemed to fit quite comfortably with the paternalistic attitude embodied by the Department of Native Affairs (DNA). At this stage, Ivan Evans explains, the DNA 'viewed itself, and was perceived by an appreciable number of Africans in the reserves, as safeguarding their interests in a rapidly transforming world' (Evans 1997: 163). Thus both the missionaries and the DNA shared an attitude of 'benevolent paternalism' (ibid: 164), united – at least in rhetoric – by a shared desire to assist Africans' wellbeing in the reserves.

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<sup>32</sup> McCord Hospital was opened in 1909 by Dr James McCord, a medical missionary of the American Board. It is known for being one of the first hospitals in South Africa to train African women nurses, from 1910 (Marks 1994: 88). McCord's autobiography, *My Patients Were Zulus* (1946), gives fascinating insight into the experiences and perspectives of medical missionaries during this period.

<sup>33</sup> This was documented by A.W. Cragg, Missionary Secretary of the Zululand Mission in 'The fifty-ninth Annual Report of the Missionary Society of the Methodist Church of South Africa'. CLHR. MISC.

At the outset, the hospital was largely funded by the Methodist Church; the important financial resource that the state would quickly come to embody had not initially been realised. But this soon changed. Thus, in 1941, just after the hospital's opening, 'the Committee learnt with pleasure that the Native Affairs Department had made a grant of £300 towards the cost of a Nurses' Home'.<sup>34</sup> In addition, the Public Health Department began providing a regular grant for the treatment of infectious cases.<sup>35</sup> Throughout the 1940s, with increasing reliance on state funding, the hospital grew steadily. The total number of patient days rose from 2833 between June 1940 and June 1941, to 17,565 between June 1947 and June 1948.

The extent of the government's financial support is reflected in a published report by the mission in June 1948, speaking about the first decade of medical care at Bethesda: 'Most of this expansion has been made possible by the generous help of the Native Affairs Department of the Union Government. Indeed, the hospital is very largely a child of that Department'.<sup>36</sup> This somewhat deferential statement, however, disguised an antagonism – revealed in the minutes of the hospital board's quarterly meetings – that was growing between the hospital and the department.

When Bethesda Hospital was established, therefore, it was immediately incorporated into a wider political economy of health care provision.<sup>37</sup> The connections between ill-health and the political economy of South Africa during the period in which Bethesda was established are now well known.<sup>38</sup> Growth in the mining and industrial centres had brought about rapid industrialisation, whilst the labour migration system became increasingly entrenched and the government's segregationist agendas consolidated (Beinart 2001). Ill-health in the reserves was closely linked to a deteriorating rural economy as malnutrition, TB and other infectious diseases – virtually unknown prior to colonial expansion – became increasingly widespread as well as, in Zululand, the additional burden of malaria (Marks & Andersson 1992; Packard 1989). Efforts at salvaging the reserves through the 'betterment' scheme largely failed, yet served to increase political tensions between peasants and chiefs (Evans 1997: 201). By the mid-1940s maize production was at a minimum, and agricultural instability was

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<sup>34</sup> Minutes, Zululand Mission Committee. 23<sup>rd</sup> Jan 1941. CLHR. MS18 690.

<sup>35</sup> Bethesda Hospital report, Oct – Dec. 1940. CLHR 197542 No.7.

<sup>36</sup> 'Reports and Statement for the Year 1948'. CLHR. 197542 No.5.

<sup>37</sup> This is true not only of mission hospitals in South Africa at this time, but throughout the colonies of Asia and Africa (Hardiman 2006).

<sup>38</sup> See Marks (1997b) for a literature review covering this issue, and Etherington (1996) for an overview of historiographical approaches to the study of missions in South Africa.

compounded by periodic droughts and floods. Increasing political pressure and the need for a sustained workforce eventually compelled the government to turn its attention to the scale of African ill-health. In rural areas, the government acted to co-opt a growing network of mission hospitals to address health needs in these areas otherwise lacking in any form of health care facility.

These years coincided with a period of intense debate and contestation within the government over the way forward for health care delivery. Indeed, the 1940s was a period that witnessed the emergence of a radical vision of reform. Given the increasing severity of the health crisis, and the financial shortcomings of the provincial hospital system as a result, in part, of increasing numbers of Africans seeking hospitalisation, the Department of Public Health (DPH) set out to investigate new methods of health care delivery (Jeeves 2000: 247). It appointed a National Health Services Commission (NHSC) in 1942 headed by Henry Gluckman, who would later become Minister of Health between 1945 and 1948. The recommendations of the final report of 1944 were radical. It suggested the creation of an inclusive National Health Service which would serve, racially and geographically, all areas of society. Linked to this was the central proposition of a shift away from a hospital focused, curative treatment, to an emphasis on preventative care that would be provided through smaller, local clinics and health centres. Gluckman stated it thus: ‘our job is to formulate a plan where hospitals would be kept empty’ (quoted in Digby 2008: 492).<sup>39</sup>

This progressive approach of social medicine adopted in the 1940s depended crucially upon several key figures, including Gluckman, occupying central positions within the DPH at the time. Another was George Gale, mentioned earlier for having inspired initial plans for a hospital in Ubombo whilst working at Tugela Ferry, who was later appointed by Gluckman as Chief Medical Officer and Secretary of Health in 1946. Gale was an important spokesperson for community-based health care, strategically positioned at the heart of the government (Marks 2000: 190). He drew upon the example of the Pholela health centre, set up by Sidney and Emily Kark in Natal in the early 1940s, to promote rigorously a health care strategy based on community-oriented clinics (Marks 1997c: 453). The Karks’ health centre was a model that was to become influential not only within South Africa, but during the resurgence internationally of primary health care in

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<sup>39</sup> This coincided with similar reforms in the UK, with the Beveridge Report of 1942 – ‘a radical blueprint for a visionary welfare state’ (Digby 2008: 486) – and the creation of the National Health Service in 1944.

the 1970s and 80s. Following from their example and with Gale's determination and political clout, between 1946 and 1948, nearly 40 similar health centres were established in some of the poorest parts of South Africa (Marks 2000: 200).<sup>40</sup>

In Zululand, the need for outreach was identified and pursued by missionaries, albeit with very minimal means, during the same period. Helen Sweet highlights the role of nurses in particular who established outreach clinics in remote areas during the 1930s and 40s at the same time that missionary hospitals were being formed, arguing that this was 'the most significant development' of the time (Sweet, forthcoming: 21). The first medical missionary of the Methodist Church in the region was a nurse called Hanchen Prozesky, who worked alone and allegedly travelled by horseback and on foot to visit people in various parts of the district. She worked at the Kosi Bay clinic of the Threlfall mission, set up by the Methodist Church of South Africa in 1917, and retired many years later in 1940.<sup>41</sup> When Robert Turner began his work in 1937, he visited Kosi Bay amongst other locations on a regular basis. For the twelve months ending in June 1941, a total of 449 patients were seen by Turner on a monthly tour 'embracing a large part of the Ubombo district'. This compared to 129 inpatients and 816 outpatients treated at Bethesda during the same period, so constituted a sizeable portion of Turner's work.<sup>42</sup> Nevertheless, he met with various obstacles that prevented him from setting up permanent clinics able to function in his absence:

Endemic malaria is present in by far the greater part of the district. While clinics should ever be kept before us as an ideal, it will take many years before much can be developed. Local girls, accustomed to malaria, are not yet at a stage when, after passing Std. V or VI, they are prepared to spend several years getting a nurse's training. Matrimony fills their horizon! To send "high veld" girls down means trouble with malaria.<sup>43</sup>

Nevertheless, in 1943, Kosi Bay clinic moved to a new site which had been granted by the Native Affairs Department, along with a further incentive of £500, to set up a larger clinic called Manguzi which was to become a separate hospital. According to the minutes of a meeting of the Zululand mission in 1946, Dr Gluckman himself – by now the Minister of Health – commended Manguzi clinic and made it clear that 'his whole-hearted support and enthusiasm...would be forthcoming'.<sup>44</sup> With the support of the

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<sup>40</sup> For discussions of individual examples, see Seekings (2005) on the Institute of Family and Community Health, and Phillips (2005) on the Grassy Park Health Centre in the Western Cape.

<sup>41</sup> 'Kosi Bay Native Mission Hospital. General Report'. 1940. CLHR. 197542 No.7.

<sup>42</sup> Bethesda Hospital report, 30<sup>th</sup> Jun 1941. CLHR. 197542 No.7.

<sup>43</sup> Turner to Nichols, 10<sup>th</sup> Nov 1943. CLHR. 197542 No.6.

<sup>44</sup> Minutes, Zululand Mission Committee, 18<sup>th</sup> Feb 1947. CLHR. MS18 690.

church, Manguzi developed into a larger hospital under the work of a German missionary, Dr Schwalbe, who began there in 1951.

The government was initially receptive to the idea of clinics because of the extreme financial burden faced by provincial authorities at the time. Clinics were thus perceived as a cheaper solution for treating African ill-health. But due, in part, to the new political agendas of the National Party after 1948, most of the commission's ambitious proposals were never put into practice. To pursue them, some authors argued, would have involved 'a drastic restructuring of the social order... well beyond the white consensus' (Marks & Andersson 1992: 158). Indeed, most of the small number of health centres that had been created in line with the report's suggestions had closed down by the 1960s due to a lack of funds (ibid: 158; see also Jeeves 2005). As Marks points out, however, the apartheid government cannot be held solely to blame for abandoning the progressive agenda laid out in the report. Even before the Nationalist Party victory in 1948, the Prime Minister Jan Smuts had already yielded to the political pressure of the provincial authorities, especially Natal and the Transvaal, who felt threatened by the possibility of hospitals moving under centralised state control. He permitted for hospitals to remain in provincial hands, rather than for centralised control under the Department of Health that was recommended by the report (ibid: 201). Furthermore, as the political idealism of the war years subsided, increasing resistance came from within the medical profession itself. Both district surgeons and private medical practitioners 'feared the possible encroachment on their practice by new-fangled health centres', and mounted political pressure against the plans (Marks 1997: 455). Nonetheless, Marks argues, 'Gale's concern for the health needs of rural Africans and his support in the Department of Health was crucial in ensuring the survival of at least some of the health centres even after the Nationalists came to power' (Marks 2000: 190).

The assertion of control by provincial authorities in the face of potential threat from the Commission's report was revealed on 25<sup>th</sup> April 1944, when Mr Hosking of the Provincial Council visited the Zululand Mission Committee meeting which was held in the Wesley Hall in Durban. His statement to the Committee was summarised in the minutes as follows:

...he wished to discover, on behalf of the Provincial Executive, the extent of our medical work in Zululand. He thought the Native Affairs Department had been generous. There was a new outlook in the Provincial Council toward hospitalisation. They intended to develop rural hospitals. It was the desire of Dr. Stevenson to set up a hospital in every rural area and further, to develop the



programme of Clinics. The Church had been too modest in making known the nature and extent of its works and in appealing for public grants from their supporters. In the future, grants would be considered and given on the basis of services rendered. Competition in mission hospitals in the same rural areas would be discouraged. It would be desirable that each Church and missionary society should concentrate on its own sphere of work and for effective services under these conditions he was sure that substantial grants would be given.<sup>45</sup>

This was an important moment that signalled an anticipated rejection of the recommendations of the NHSC. Mr Hosking's timely statement, immediately prior to the publishing of the report, indicated an urgent desire to assume control on behalf of the province by taking over hospital funding from the DNA. It conveyed the government's support of the provincial hospital system at the expense of the report's proposed model of centralised control. This was a promise not only of more funds to the hospital but also constituted a warning of greater state involvement expressed explicitly through a caution that, in future, financial assistance would be dependent upon certain conditions being met; a move that contrasted with the more piecemeal approach of the DNA. These conditions indeed became more rigorous and standardised, such as the grading system for hospitals that determined how much money they received.

As forecasted in Mr Hosking's speech, three years later in 1947 the Provincial administration took over from the DNA the role of hospital subsidising. That year, grants were delayed by nine months whilst the Provincial Administration established its new policies pertaining to mission hospital funding. When the grant finally arrived, it was based on the same scale as the DNA grants of the previous year, so the hospital failed to benefit from the usual increase. The Medical Superintendent, Dr J. Farren, stated in a report at this time:

At present, income just about balances expenditure, but there is no leeway to meet the rising costs and necessary expenses. As a Hospital becomes more efficient so does its expenditure, but there is much smaller increase in income. There is no doubt that the hospital is expanding, and if developments planned by the Railways and the Government in the area do materialise, we shall be called upon to double our size within a year.<sup>46</sup>

Such a statement was one of a number that together expressed an increasing sense that the hospital's financial costs were – and should be – the government's responsibility. A year later in 1948, Dr. Farren reported: 'The Province has decided to give us an annual grant of £700. This is an advance of only £100 on what we received last year from both N.A.D. and Province – in spite of the growth of the work.' The committee supported

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<sup>45</sup> Zululand Missions Committee Minutes. 25<sup>th</sup> Apr 1944. CLHR. MS18 690.

<sup>46</sup> Bethesda Hospital report. Oct - Dec 1947. CLHR. MS18 690.

him by stating that this amount was ‘far from adequate to successfully run the Hospital and cater for the needs of the people’.<sup>47</sup>

Tensions thus grew between the hospital and the increasingly powerful provincial administration who continued to fall short of their promised financial commitment. The Department of Public Health continued to fund treatment for infectious cases, but lacked the centralised administrative capacity that some of its senior figures had hoped for as set out in the commission’s report. In the meantime, the health situation continued to deteriorate and emphasis returned to treating infectious diseases such as TB, rather than the longer term preventative strategies that had constituted the radical ideals of the social medicine approach. Realising that the mission was filling a welfare gap for which the state should really be providing, and suffering continued resource shortages, doctors became increasingly demanding of the provincial authorities. The relationship was one of mutual benefit, therefore, but one that was becoming increasingly fraught because of the government’s delayed and insufficient payments.

The apartheid government – coming to power in 1948 – continued to fund the hospital and, unlike the previous segregationist government, quickly developed plans for the establishment of independent ‘homelands’. They were thus driven by an additional incentive to develop the services of health and welfare in these areas, eager to create legitimacy for the ‘homelands’ and to make the project viable and sustainable. Thus even though rural African areas continued to be neglected, the bureaucratic apparatus of government tightened considerably under apartheid. Yet, as will become clear later in the chapter, the transfer of hospital control to the KwaZulu ‘homeland’ government in 1982 involved a catastrophic level of administrative inefficiency.

The government called a Provincial Hospitals Commission in 1951, giving Dr Farren the formal opportunity to outline his earlier sentiments. His memorandum laid out the main resource shortages suffered by the hospital and possible suggestions for how these might be relieved, including a rough breakdown of expenditure and a recommended grant to cover these basic costs. It also outlined the overall benefits of mission hospitals including the willingness of staff to work in remote areas:

By virtue of their missionary staff, they are supplying hospital services in areas where it would be impossible to place Provincial Hospitals, and therefore relieve

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<sup>47</sup> Bethesda Hospital report. Jan – Mar 1948. CLHR. MS18 690.

the pressure on beds in the Central Hospitals. They also serve to limit the spread of infectious disease by treating patients before they travel far in search of aid.<sup>48</sup>

Whether intentionally or not, this statement drew upon the wider concerns held by the state at that time. Firstly, the control of infectious disease was a huge preoccupation, particularly given the rapid urbanisation of industrial areas, and considerably influenced state policy on health reform for much of the twentieth-century (Marks & Andersson 1992). The government's subsidising of the treatment specifically of infectious diseases at Bethesda and other rural hospitals, for example, was evidence of its strategic, rather than overall, interest in the health and well-being of the African population. Secondly – and closely related to the first – were the myriad strategies in place to control the movement of people in the pursuit of the aims of apartheid, which in the 1950s and 60s became much more regimented.

In Farren's final point regarding the advantages to the state of mission hospitals, he wrote:

In the past Mission Hospitals have taken a considerable burden off the shoulders of the tax-payer. Their running costs are much lower than those of Provincial hospitals, owing partly to their missionary staff, and partly to the help given them by their Missions. The moral responsibility for hospital services having been looked upon more favourably by the public and having been accepted in principle by the Provincial Administration it is obvious that Missionary bodies should now be relieved of the financial burden of providing the considerable services they have done in the past. In particular capital expenditure must be met by the Provincial Administration.<sup>49</sup>

Unusually candid, this statement made perfectly clear the mission's attitude towards funding. This illustrates once again that since the initial reception of a government grant in 1941, the language used by mission doctors and board members had shifted from one of pleasant surprise and grateful acceptance, to one increasingly characterised by entitlement and demand.

In 1949, a year after the National Party came to power, the Department of Health increased its funding to Bethesda specifically to treat patients with infectious diseases.<sup>50</sup> Perhaps George Gale's continued involvement in the Department as Secretary of Health and Chief Medical Officer until 1952 partly accounts for this continued support of health care in rural areas, even after the coming to power of the Nationalists. By 1956,

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<sup>48</sup> 'Evidence to be presented to the Provincial Hospitals Commission in accordance with the Commission's terms of reference', Bethesda Hospital, 1951.CLHR. 197542. No.7.

<sup>49</sup> Ibid.

<sup>50</sup> Pretorius, Secretary for Health, Pretoria, to Secretary to the Treasury, 29<sup>th</sup> Apr 1949. NASA GES 1399 369/19.

TB had escalated in the region and was placing a severe strain on the hospital. Dr Turner – who returned to Bethesda in 1953 to take up the position of Medical Superintendent again – wrote to the Chief Regional Health Officer of Natal in January 1957:

The position with regard to tuberculosis patients here is becoming impossible. We have over thirty in at present, packed two to four in cubicles which are a doubtful size for two, and four or more rondavels, which are needed for other purposes... The position has now arisen whereby we MUST send a few patients home immediately, and any cases coming in will have to be returned home for lack of accommodation, irrespective of their infectivity.<sup>51</sup>

Following communication between Durban and central government, the Secretary for Health in Pretoria granted the erection of a 12-bed TB ward.<sup>52</sup> Over the following few years, the government was largely preoccupied with keeping infectious diseases under control, intermittently providing an increase in grants for this purpose. In 1962, the State Health Department funded a new tuberculosis block housing sixty patients.<sup>53</sup> Overall, government grants increased during the 1950s and early 1960s but generally not enough to meet the growth of the hospital, at a time when ill-health in the region was overwhelming. Therefore deficits continued to be a problem. By 1963, the needs of Bethesda had become dire, and the prospect of closure voiced.<sup>54</sup> In 1965, government grants increased to meet 90 per cent of the hospital's running costs, although staff shortages persisted.<sup>55</sup> Annual reports from 1966 and 1968 both suggest that rising costs were met by increased grants from both the State Health and the Provincial Health departments, suggesting a greater degree of commitment by the government and a more prompt and responsive administration than in previous years.<sup>56</sup> In 1969, due to a failure of the hospital to employ a second doctor, the hospital was re-graded to Grade C, which meant that grants were once again reduced.

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<sup>51</sup> Reeler, Chief Regional Health officer, Natal, to Secretary for Health, Pretoria, 29<sup>th</sup> Jan, 1957. NASA. GES 1399 369/19A.

<sup>52</sup> Secretary for Health, Pretoria, to Chief Regional Health officer, Natal, 9<sup>th</sup> Feb 1957. NASA. GES 1399 369/19A.

<sup>53</sup> Bethesda Hospital Annual Report 1962/1963. This document was kindly lent to me by Dr Steve Knight.

<sup>54</sup> Rist to Reece, 19<sup>th</sup> April 1963. CLHR. 197542 No.5.

<sup>55</sup> Minutes, Zululand Mission Committee, 5<sup>th</sup> Oct 1965. CLHR. MS19 099.

<sup>56</sup> Bethesda Hospital Annual Report, 30<sup>th</sup> Sep 1966/ 30<sup>th</sup> Sep 1968. Both held by Dr Steve Knight.

## **‘Homeland’ politics and the beginning of an uneasy transition in the 1970s**

The Bantu Self-Government Act of 1959 began to consolidate separate administrative structures within the ‘homelands’ to which the central government increasingly attempted to transfer administration of industry and welfare in these areas. The ‘homeland’ of KwaZulu was officially formed in 1970 and finally, in 1977, was granted internal self-government.<sup>57</sup> The process of transferring power, however, was long, uneven and incomplete, involving considerable bureaucratic complications that were felt on the ground by institutions such as Bethesda which were reliant on the state.

A Manguzi Hospital report of 1974 raised one of the central difficulties:

All the mission hospitals are having difficulty with multiplicity of authority. The hospitals are run by mission staff under a mission hospital board, financed for running and capital costs by the Department of Bantu Administration through the Department of Health. In many areas the Homeland Government too is playing a significant role. Thus most mission hospitals have to deal with four different and independent authorities. A very difficult situation for all concerned.<sup>58</sup>

This statement summarised a theme that had emerged strongly over the years of mission control at both Manguzi and Bethesda Hospitals: fluctuation of responsibility between different departments further stalled access to financial resources by both hospitals.

Another report from 1970 stated:

When we ask for funds and permission to develop, the repeated cry of the Government Departments concerned is that they wish to plan Far Northern Zululand as a whole... and are not prepared to make any expensive decisions until this has been done. It is frustrating to see present opportunities being lost and development stunted...<sup>59</sup>

The situation escalated in the 1970s, partly a result of the fact that as apartheid became increasingly subject to political criticism and pressure, the government took quicker strides in pushing through its plans for independent ‘homelands’. This led to crippling inefficiencies in the system of hospital funding. In 1972 the Bethesda Hospital board appointed a committee to investigate the ‘deadlock’ that had emerged over the provision of grants between the Provincial Administration and the Departments of Bantu Administration and Development and of Health.<sup>60</sup> Likewise at Manguzi the previous year, the board minutes describe a situation of ‘utter confusion’ as none of the various

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<sup>57</sup> For a thorough discussion of the formation of the KwaZulu ‘homeland’, see Maré & Hamilton 1987.

<sup>58</sup> ‘Manguzi Methodist Hospital Synod Report’ 1974. CLHR. MS19 099.

<sup>59</sup> Manguzi Hospital report, 24<sup>th</sup> Nov 1970. CLHR. MS19 099.

<sup>60</sup> Minutes, Bethesda Hospital board meeting, 16<sup>th</sup> Nov 1972 CLHR. MS19 099.

authorities appeared to be including provision for the hospital within their budgets.<sup>61</sup> Despite repeated appeals for clarification, as well as for further grants to meet the hospitals' growing costs, the confusions and delays continued until eventual takeover in 1982. It is clear that considerable and often debilitating inefficiencies resulted from the government's project of seeking to establish the legitimacy of the bantustan authorities by transferring the institutions of welfare to their administrative control. This supports Price's claim that 'the political priorities of "independence"... over-ruled the interest in improved health care' and at the same time, 'allow[ed] the White government to deny responsibility for both ill health and poor services' (Price 1986: 165-6).

The increasing political control of the state over Bethesda Hospital took place gradually after the latter's inception, yet as I have shown, this was rarely accompanied by sufficient funds. On the contrary, financial accountability was even further evaded by devolving responsibility onto the less specialised Department of Bantu Affairs and later the KwaZulu Department of Health. This, as Digby points out, was 'a particularly blatant omission given that the department continued to resource bantustan health budgets' (Digby 2006: 423). Such a gap between the rhetoric of rural health care and its effective practice was significant, for it indicated that the state was forced to respond to increasing political pressure, but lacked the genuine political will to solve the problem of ill-health in rural areas. Marks & Andersson argued in 1988:

The creation of this bewildering and wasteful array of health departments has not only been intended to lend credibility and legitimacy to the government's ethnic collaborators and provide jobs for the rural petty bourgeoisie; it has also enabled the state to slough off any responsibility for conditions in the rural areas, and to give the misleading impression that health in South Africa is improving' (Marks & Andersson 1988: 193).

Yet whilst the apartheid government attempted to assert increasing control over the hospital, bureaucratic inefficiencies inevitably undermined its efforts, generating escalating costs and drastically inhibiting effective delivery. Another challenge to state authority operated at the ideological level, for whilst, as I suggested in the previous section, the Methodist mission's vision for health care initially sat comfortably with that of the DNA, the increasingly harsh and oppressive apartheid system was drastically at odds with the missionary outlook.

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<sup>61</sup> Minutes, Bethesda Hospital board meeting, 23<sup>rd</sup> Nov 1971. CLHR. MS19 099.

## **Nurse training, mission culture and emerging dissent**

Mission education in South Africa, especially for women and girls, was strict and disciplined. Educational and occupational training was invariably part of a broader pedagogical instruction in religious practice, lifestyle, leisure pursuits and good manners. Deborah Gaitskell's discussion of Anglican and Methodist Church hostels for women in Johannesburg offers an interesting example, showing how missionaries were motivated both by the need to fill the capitalist labour market for domestic servants as well as by a desire to nurture the 'moral purity and security of women' in a dangerous urban setting that, they felt, put at risk these 'intrinsic value[s]' of womanhood (Gaitskell 1979: 45).

Nurse training encapsulated similar sentiments, and usually entailed a draconian set of rules by which nurses were expected to behave, according to the wishes of their senior matrons who assumed a variety of roles, both kindly and maternal as well as that of a firm superior. Shula Marks observed that in the 1940s and 50s in South Africa, 'the regimentation of the nursing hierarchy was formidable' (Marks 1994: 103). Bethesda was no exception. The relationship between doctors, nurses and patients, and between white and black nurses occupying different levels of the professional hierarchy, is one of the clearest reflections of wider political and cultural discourses within the hospital and in the attitudes of its staff. While in South Africa as a whole, junior white nurses were subjected to the same strict disciplining as their black counterparts, at Bethesda, the hierarchical relationship between senior staff on the one hand, and junior nurses and patients on the other, reflected powerfully a racial divide. In the ongoing attempts of the hospital board to recruit white missionary nurses Dr Farren – medical superintendent between 1944 and 1953 – wrote in a letter to Miss Evard, a sister then working at King Edward Hospital in Durban in 1952: 'Although our patients are primitive, they are a cheerful lot. You would find an absorbing interest in the training and "mothering" of the nurses.'<sup>62</sup>

White sisters' attitudes towards, and treatment of, their students did indeed appear, as Farren's letter suggested, to resemble a style of 'mothering' towards children, characterised by strict disciplining and safeguarding. One nurse, now a senior matron at Bethesda, recalled with amusement her memories of a male nursing tutor, Mr Oram,

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<sup>62</sup> Farren to Evard, 8<sup>th</sup> Dec 1952. CLHR. 197542 No.5.

who worked at Bethesda between 1965 and 1979 and who – I discovered through various conversations and rumours – had gained rather a reputation for his strict approach:

I can tell you my story. I was with a friend and we were in the kitchen. We were there because we were expected to make cocoa for patients sometimes. While we were doing that, we were talking in Zulu. We were not allowed to speak Zulu at all during shift time. While we were speaking to each other, Mr Oram caught us and said, “Go to my office”. In his office, we pleaded with him that the shift is over. He said, “You are still wearing your uniform. Therefore the shift is not over!” He gave me the punishment that, from 7 until 8 every morning, I had to go to laundry and be assigned a different task each day. This lasted for a whole month! Just for speaking Zulu! He would give all sorts of punishments; working with your cap off, working with your shoes off, washing the walls, and always for one month. The punishment always lasted that long. It was so cold to be working with no shoes!

Another nurse told me, initially with a serious tone, yet gradually turning to laughter:

When you did funny things, they treated you like children. But we were adults... I remember one time when Mr Oram locked me in the linen room, I had to stay there for hours. I couldn't eat anything. When I wanted water, I had to knock loudly on the door and wait for someone to come.

Lena Turner was described as a committed and hard working nurse and teacher. She was also allegedly extremely strict with the junior nurses and students. Her own description of her experiences at Bethesda dedicate several pages to describing light-heartedly the behaviour of nurses – what she describes as their “cheek and insubordination” – and her own response to this. Some of these incorporated somewhat crude racial or gendered narratives:

Amongst the nurses there were tribal fights in the dormitories. Revenge was prevalent, and it became evident that it would be wiser to employ Zulu girls only. There was a strong spirit of rivalry between girls of a different tribe. On one occasion a Xkoza [sic.] girl broke into the box room and slashed all the dresses of a Zulu girl because of a small demeanour. Another Swazi girl had to be shut up in a room as she threatened to beat up another nurse with a heavy metal instrument. So never a dull moment.<sup>63</sup>

After discovering that one nurse had given birth during the night without them realising, Lena told her husband: “Well she can stay there [in the side room] and have no visitors. Otherwise the others will think she is very clever”. Nurses were repeatedly penalised and sometimes dismissed for leaving the premises without permission, for trying to pursue romantic relationships and, on one occasion at Manguzi Hospital, for assisting a friend with an abortion.<sup>64</sup> Such concerns reflected a wider unease. As Marks describes, ‘the virginity of young African girls was a recurrent preoccupation of missionaries,

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<sup>63</sup> Lena Turner, unpublished autobiography, pg. 38.

<sup>64</sup> Manguzi Hospital report, Feb 1972. CLHR. MS19 099.



administrators and Christian Africans in twentieth-century South Africa' (Marks 1994: 104; see also Kumwenda 2005). To be a nurse meant also to lead a respectable, Christian lifestyle. Thus discipline of this kind was an integral feature of nurse training.

Mr Oram's autobiography describes his strict and formal training in England, an account replete with jovial tales of his own misdemeanours as a young trainee in 'a profession dominated by female battle axes' (Oram (unpublished): 21). His stories of becoming a professional nurse evoke the experience of passing from childhood to adulthood, implicitly reaffirming the hierarchical status between students and their tutors. In South Africa, though, this took on a racial dimension. He writes: 'The black nurse has a different attitude to life than that of her white colleague but her skill has blossomed out with a higher standard of training' (ibid: 38). Here, an implicit explanation of 'cultural difference' is drawn upon to define uneven degrees of ability, signified by membership to different racial groups, that only a strict and formal nurse training can iron out.

Yet at other times, evident in reports that he wrote to the hospital board on behalf of the nursing services, Oram displayed a sharp awareness of the social and educational inequities that placed African nurses at a disadvantage. In a report written in June 1970, he recorded that 12 of 13 nurses had recently passed their examinations compared to a national average of 59 per cent, a success he attributed to the quality of teaching at Bethesda. In his typically crass yet serious style, he continued:

This prompts me to comment on the low standard of education resulting from the Bantu Education Act. The general knowledge of the African has deteriorated rapidly since the introduction of the present system in 1955. At the present time nurses with a Junior Certificate cannot calculate the simplest subtraction or multiplication without using the palms of their hands as a slate! Their general knowledge is less than a Std. IV white scholar. They have told me that their teachers instruct them when calculating in fractions to work to the nearest half! When coming here they are unable to express themselves in simple English. In the realm of education "divide and rule" has brought all it was designed for. This education system is an indelible blot in the history of a so-called Christian country. We as Christians must resist this insidious lowering of the education of the largest portion of the population.<sup>65</sup>

Oram's statement, devoid of the formality and equanimity of other entries in the hospital's reports and minutes, provides a window into a more subversive commentary that was perhaps more frequently spoken rather than written down. Such comments reflect an engagement with wider trends of political opposition in South Africa; the

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<sup>65</sup> Bethesda Hospital quarterly report, Jun 1970. CLHR. MS19 099.

1970s was a period of repeated boycotts and protests against Bantu education in schools (Maré & Hamilton 1987).

In the 1970s, then, there was increasing incongruity between the position of the hospital and the ideologies and bureaucratic applications of apartheid. This became apparent particularly over disputes relating to administrative and salary structures. For example, in 1977, following the demotion by the state of the hospital administrator, Mr Ryan, to the position of Coloured Assistant Clerk at one fifth of his previous salary, the hospital protested in writing with a full motivation and managed to evade the strictures of the government's discriminatory policies by meeting the salary difference using the donation account of the church. Thus they rejected the policy, yet in a manner to which the government could not object.<sup>66</sup> In other instances, it is clear that the government's racial policies inhibited the work of the hospital. A statement from committee minutes dating 23<sup>rd</sup> August 1968 read:

Dr Turner had made enquiries of the Nursing Council concerning the possible appointment of an African Matron.<sup>67</sup> The Council replied that it was policy to employ Bantu as much as possible for the nursing of Bantu patients, but no White person could be employed under the control of anyone other than a White person. Dr Turner reported that after much thought, he could not see any way to fulfil this regulation without impairing the efficiency of the Hospital.

In 1977, the hospitals were told 'quite emphatically' by the president of the Nursing Council that this regulation no longer existed.<sup>68</sup> The many years of trying to enforce apartheid segregation within the nursing profession had eventually become unsustainable, due partly to increasing political pressure that developed throughout the 1970s, and even more because of the huge, nationwide shortage of nurses that ultimately necessitated the recruitment of black nurses to all levels of the profession (Marks 1994: 189). In addition, the government encouraged the employment of skilled Africans whenever possible within the bantustans.

Another indication of the shift towards a less conservative approach at the hospital during the 1970s was the attempts by Dr Hackland to challenge some of the crudest manifestations of a taken-for-granted hospital hierarchy. During an interview, Priscilla and Daryl Hackland described aspects of hospital life under the Turners that they were eager to do away with quickly. 'Things were organised in a very old fashioned way that

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<sup>66</sup> Bethesda Hospital quarterly report, 31<sup>st</sup> Jan 1977. CLHR. MS19 099.

<sup>67</sup> 'Matron' denotes the most senior nursing position.

<sup>68</sup> Manguzi Hospital Report, Aug 1977. CLHR. MS19 099.

fell in line, in some ways, with apartheid', Priscilla said. 'During meetings, all the whites would sit separately down the side of the hall. That had to change. We got rid of that straight away'. They wanted to avoid the prior system as they saw it, in which 'authority was very much in the hands of the superiors'. Over time, they tried to introduce a system of 'participative management' by, for example, holding open staff meetings on a weekly basis. Whilst it took a long time for people to get used to a new way of doing things, they felt that they were largely successful. Thus, whilst a rigid nursing and medical hierarchy persisted at Bethesda as it did in South Africa at large, Daryl and Priscilla Hackland did, in certain important ways, challenge the assumption of white superiority that was often, even amongst the more 'liberal' ilk of mission doctors and nurses, 'both commonplace and commonsense' (Marks 1996: 147).

Apartheid ideology, therefore, was increasingly at odds with the attitude of the missionaries running the hospital, who began to challenge explicitly its overt racial discrimination. Ironically this subversive commentary at Bethesda ran alongside the persistence of a dogmatic Christianizing of 'heathen' patients that carried its own profound and deep-seated race assumptions. I turn now to a more detailed consideration of the last decade of mission control prior to takeover in 1982, to demonstrate the ways in which the mission reasserted its own vision of health care in the face of increasing state encroachment and imminent takeover.

### **'A whole-man type of ministry': the renewal of community health amidst impending takeover**

In the years leading up to Daryl Hackland's arrival in 1970, hospital reports suggest that Turner had become tired and frustrated with the hospital's ongoing financial difficulties and with the ever increasing encroachment of the state on hospital affairs. He emphatically stated at one point, 'Bethesda was begun as a MISSION hospital, and we are still seeking to make that title real.'<sup>69</sup> Such sentiments were compounded by, perhaps also helped to produce, a feeling of inertia with regard to the spiritual work of the hospital that was expressed repeatedly through complaints to the board about the lack of a hospital evangelist.

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<sup>69</sup> Bethesda Hospital quarterly report, 30<sup>th</sup> Sep 1969. CLHR. MS19 099.

When Daryl Hackland and his wife, Priscilla, arrived – free of the burden carried by their predecessors of years of frustration and hard work – they seemed to bring with them a new lease of life. In Hackland’s first report of March 1970, three months after his arrival, he commended Dr and Mrs Turner for having ‘served to their uttermost’, and to the staff for facilitating a smooth cross over. Yet he wasted no time in laying out his own initiatives and the changes he intended to bring about:

Conscious that we are not only called to preach and to heal but also to teach we have a concern to commence this programme. We have started in a small way with Occupational Therapy work, but this must be extended to include Health and Hygiene programmes at our Clinics and even basic agricultural projects on the 5-6 acres we have available. The problem is we have no clinics – we must start and we require a further vehicle for this purpose.<sup>70</sup>

Thus began a renewed effort to provide medical outreach and an attempt to widen the breadth of the hospital’s work, as well as its geographical reach, with a more holistic approach to health care.

Hackland’s enthusiasm for setting up clinics must be understood in relation to changing international trends in health policy. During an interview, Hackland recalled in particular the Alma-Ata Declaration of 1978. Alma-Ata, a city in the former Soviet Union, was the location for a conference in September 1978 organised by the World Health Organisation, that defined and set out recommendations for primary health care as a global priority for achieving their stated goal of ‘Health for All’. Geared towards community-oriented medicine, the declaration emphasised the need for “appropriate technology”, whilst challenging medical elitism and promoting health care as a mechanism for social and economic development (Cueto 2004: 1867; see also Litsios 2008). The effect of this conference was to accelerate an international shift towards a focus on primary health care in the medical world which was influential in South Africa, marking the emergence of a more comprehensive and preventative approach adopted by Bethesda and a number of other mission hospitals that, together, ‘formed the seed-bed for community-based health and development initiatives’ across the country (Kautzky & Tollman 2008: 20).<sup>71</sup>

Yet the role of missionary medicine was not simply as a recipient of such new global agendas but, in fact, played an important part in setting them out. The Christian Medical

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<sup>70</sup> Bethesda Hospital quarterly report, 31<sup>st</sup> Mar 1970. CLHR. MS19 099.

<sup>71</sup> Others included, in particular, Elim and Gelukspan in the Transvaal, Cecilia Makiwane in the Cape, Charles Johnson and Manguzi in Natal (Kautzky & Tollman 2008: 20).

Commission (CMC), established in 1968 to advise the World Council of Churches with regard to church-related medical programs, was extremely influential. In its first annual meetings, members quickly laid out a moral agenda for health care, in which equity of resource distribution alongside holistic, community-based care, were emphasised as paramount (Litsios 2004: 1888). The CMC researched and documented existing examples of health care programmes in developing countries, three of which – in Indonesia, India and Guatemala – ‘proved critical in WHO’s conceptualization of primary health care’ (ibid: 1888). The CMC worked closely with members of WHO in the years leading up to the conference at Alma-Ata.

South Africa’s earlier test of social medicine was also an important forerunner, pre-empting this global shift to primary health care in the 1970s and 80s. The Pholela clinic, set up by Sidney Kark in South Africa in the 1940s, was an early example of the kind of model later embraced by the WHO. As Litsios points out, ‘Many similarities between primary health care and Kark’s work in Africa are evident’ (ibid: 1980). When Dr Hackland began his work at Bethesda he was influenced not only by international developments in health care, but also by the missionary contribution to medical knowledge and practice – both in South Africa and beyond – that preceded the conference. Also aware of Dr Turner’s earlier efforts, he built on previous local attempts to provide care beyond the site of the hospital itself, yet in a much more systematic way.

The apartheid government was also quick to adopt the language of primary health care, yet as Marks & Andersson predicted in 1983, this revival of the *rhetoric* of the earlier aims of the 1940s Gluckman Commission was largely unmet by a commitment to its implementation ([1983] 1992: 160).<sup>72</sup> In 1986, for example, indicators suggested an ‘overwhelming dominance of high technology curative medical care consuming about 97 percent of the health budget with only minor shifts towards community-based comprehensive care’ (Jinabhai *et al.* 1986: 163). Rather, Marks & Andersson, amongst others, interpreted this shift as a form of state propaganda amidst attempts to secure legitimacy for the ‘homelands’ (Marks & Andersson 1988; Price 1986; de Beer 1984). Yet despite this apparent pretence on the part of the government, and faced with the continual struggle, therefore, of financial constraints, real efforts were made by

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<sup>72</sup> Furthermore, the ANC’s current health care system based on an expansion of primary health care once again bears similarities to Gluckman’s 1944 report (Marks 1997c).

missionary doctors and nurses working at Bethesda to implement a primary health care strategy.

Thus the 1970s and 80s bore witness to a simultaneous emergence both of the intensely controversial bantustan system twinned with the rise of the Inkatha movement, and a radical global vision of a primary health care model encompassed by the WHO mandate of 'health for all' that was pioneered by mission doctors within bantustan territory. What have been largely neglected in the literature thus far are the relative gains made by the missionaries after 1982 due to the 'homeland' government's willingness to pursue and to fund the primary health care initiatives (within the constraints resulting from financial dependence upon an apartheid state geared towards massively unequal distribution of funds). In this section, I argue that – despite these enormous constraints and the overwhelming inadequacy of service provision in the KwaZulu 'homeland' – the work of nurses and doctors under the mission's lead in the 1970s and 80s laid the infrastructural foundation for the current primary health care network in this district.

These achievements took place – and were made possible – in the context of a wider upsurge of support for primary health care across South Africa, spurred by the international excitement generated by Alma-Ata, and the subsequent emergence of an network of organisations involved in the promotion of PHC nationally, called The National Progressive Primary Health Care Network (NPPHCN). Related to this, numerous small-scale health projects were set up across the country, of which the Bethesda initiatives were one example (Kautzky & Tollman 2008: 22). The ANC also embraced a community-based health care agenda, a priority that has persisted to the present day and is now referred to as Community Oriented Primary Health Care. Returning to the lessons of South Africa's attempt at social medicine in the 1940s through a rediscovery of the Gluckman report of 1944, the ANC framed its National Health Plan based largely upon the PHC approach (ibid: 23).

By 1971, preventative medicine programmes were in place across the region surrounding Bethesda, including immunisation of adults and school children against typhoid, immunisation of under 5s, and health education. In addition, a 'Family Health Clinic' had been set up at the hospital, seeing 256 families regularly. Coupled with these initiatives was a greater focus also on 'spiritual out-reach'. Hackland, who was

himself a trained minister, initiated ‘a definite evangelical preaching programme by Staff of the Hospital to their areas’.<sup>73</sup>

A year later, Hackland reported: ‘Clinics continue to gather momentum and emphasis on prevention [is] particularly thrilling’. Signs were also showing that the government was beginning to take a more active role in supporting the clinics. Hackland mentioned one preventative measure by the State Health department which had recently been extended to Bethesda: the Kwashiorkor Scheme that provided free subsidised milk powder.<sup>74</sup> By 1973, the hospital was applying to take part in the government’s Comprehensive Medical Care Scheme and District Clinics. On 1<sup>st</sup> May 1973, it was agreed during a meeting that the State Health department would fund an additional doctor’s post at Bethesda to make the scheme feasible. This was granted and the necessary funds for the scheme paid to the hospital later that year.

Yet the government-initiated Comprehensive Medical Care scheme quickly developed difficulties with financing, and it rarely seemed to be prioritised by government. During the following few years, funding for the clinics was sometimes forthcoming and at other times delayed or not given at all. Once again, there appeared a dissonance between professed intentions and effective implementation. Part of this was to do with the confusion around whether accountability lay with the central State Health department or the KwaZulu government. For the state had now begun the process of trying to pass responsibility for health care provision and financing over to the KwaZulu ‘homeland’ government, as I described above. At Manguzi Hospital, a report from November 1976 identified the need for more clinics as urgent, and this frustration was compounded by the fact that the KwaZulu government had not so far carried through: ‘Permanent clinics run by Kwa Zulu Government show no signs of being established though talking has been going on for years’.<sup>75</sup> Likewise, at Bethesda during the same year, plans for a clinic in Madonela were stalled by the central government’s continued negotiations with KwaZulu: ‘The state is at present holding discussion with the Executive Council of Kwa Zulu re a clearly defined policy.’<sup>76</sup>

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<sup>73</sup> Bethesda Hospital quarterly report, 31st Mar 1971. CLHR. MS19 099.

<sup>74</sup> Bethesda Hospital quarterly report, 30<sup>th</sup> Jun 1971. CLHR. MS19 099.

<sup>75</sup> Manguzi Hospital report, 4<sup>th</sup> Nov 1976. CLHR. MS19 099.

<sup>76</sup> Bethesda Hospital quarterly report, 31<sup>st</sup> Dec 1976. CLHR. MS19 099.

Meanwhile, both hospitals continued – within their limited means – to provide outreach, and it is clear that over the course of the decade, this aspect of their work became prioritised by the mission staff themselves as a focus of exciting and innovative change and expansion motivated by the increasingly popular notion within the international medical and nursing professions of holistic, community medicine. In 1977, Bethesda Hospital’s outreach work was grouped together under the title ‘Go Ye in Christ’ and incorporated clinics, immunisation schemes, agricultural projects, health education, a soup kitchen, literacy support at the mission, and evangelising. The new title re-emphasised Christian faith as the driving motivation behind all these initiatives. The hospital report of March 1978 exclaimed:

“Go Ye in Christ” 1978 was worked out, and is at present being implemented. The thrilling moments have been to see Jesus preparing ahead of us each step of the way, one jump ahead of us. This has confirmed the reality of His guidance and His tender loving care.<sup>77</sup>

Thus health education was delivered alongside Bible study, as in the case of a five day residential course for mothers.<sup>78</sup> Later that year, a further step was taken towards systematising and standardising the community health structure when formal nurse training, leading to a Bethesda Diploma of Primary Health Care (PHC), commenced. A meeting with KwaZulu confirmed that a primary health care course would soon receive official recognition<sup>79</sup> – an indication of the increasing interest assumed by the KwaZulu government that would, after takeover, facilitate doctors and nurses in implementing PHC: a point to which I return shortly.

While it is unsurprising that a mission hospital would use biblical references in the naming of its projects, I suggest that the reassertion of religious language by mission nurses and doctors during this period – particularly in the naming of projects and official discourse – expressed an attempt to counteract the increasing intrusions of the state. This was most explicit, for example, in the following justification for a constitutional change at Manguzi Hospital in 1971: ‘It was proposed at the Medical Superintendent’s Meeting that in view of increasing Government pressure and identification with the hospitals the name of this hospital be changed to “Manguzi Methodist Mission Hospital”.’<sup>80</sup> Words seemed, at times, to carry a symbolic agency, formally reasserting ownership in the face of increasing threat.

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<sup>77</sup> Bethesda Hospital annual report, Mar 1978. CLHR. MS19 099.

<sup>78</sup> Bethesda Hospital quarterly report, Jun 1978. CLHR. MS19 099.

<sup>79</sup> Bethesda Hospital quarterly report, Oct 1978. CLHR. MS19 099.

<sup>80</sup> Manguzi Hospital report, 18<sup>th</sup> May 1971. CLHR. MS19 099.



In addition, the archival data repeatedly illustrates an integration of the missionary language of spiritual salvation with that of ‘Community Health’ and the tropes of an emerging, international field of primary health care, partly driven through NGO funding.<sup>81</sup> These newly emerging associations between mission and medicine at Bethesda echoed the outlook of the wider Christian mission approach to medicine at the time. The Christian Medical Commission, for example, emphasised the links between Christian faith, community well-being and individual health. It is, argued one of its members, only ‘when the Christian community serves the sick person in its midst [that] it becomes itself healed and whole’ (quoted in Litsios 2004: 1887). Both the missionary and medical paradigms rejected the role of health care as a service purely to cure disease, and viewed medical treatment in a wider social and educational context that valued a more holistic understanding of health and personhood. So whilst one was rooted in a religious outlook and the other in a social and policy-driven paradigm, nonetheless these similarities – and their shared rejection of a narrow curative approach to medicine – made them compatible. At Bethesda and Manguzi, the widespread shift towards a primary health care approach enabled a rejuvenation of missionary ideology through a synthesis of these two ways of thinking:

The Manguzi Community Programme is one of the ways in which this new concept of Community Health has found practical expression. It aims to provide those components of a *whole-man type of ministry* not fully catered for, at this stage, by Government Health Services.<sup>82</sup> (my italics)

This synthesis was not only semantic but achieved practically through the activities themselves, of going forth to communities, implied in Bethesda’s title of ‘Go Ye’; of taking the religious message into people’s home, thus evoking the journeying that was central to the missionizing process. The Bethesda Report of December 1977 states:

Two Health Educators joined our staff from the 3<sup>rd</sup> of January and this has assisted in a more in-depth approach to Preventative Health. Mr. Mhlanga has taken over immunisations, Tuberculosis and school work, and is involved in teaching in the wards, O.P.D. and Clinics. He will penetrate into the individual Kraals and as a committed Christian is happy to be involved with personal and Christian counselling [sic.]... School soup kitchens run by “School Health Evangelists” with World Vision’s help with salaries is also a possibility.<sup>83</sup>

A strong sense prevailed that God’s ‘calling’ was fulfilled, in particular, through outreach work, as in the following quote from a Bethesda report of August 1980:

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<sup>81</sup> By this point, World Vision and Tear Fund were both active in the area.

<sup>82</sup> Manguzi Hospital annual report, Apr 1979. CLHR. MS19 099.

<sup>83</sup> Bethesda Hospital quarterly report, Dec 1977. CLHR. MS19 099.

We believe that those involved with this aspect of our work are being called by God to support actively an outreach programme. Many lives recently have been touched by the Work and been lead by the Spirit into commitment.<sup>84</sup>

At, Manguzi, nurses and doctors were pursuing similar programmes, despite the KwaZulu Health department's stalling on the financing of clinics. Dr Draper and Dr Prozesky were responsible for pushing forward many of the initiatives, and in particular, for encouraging 'community involvement' through project committees consisting of local residents rather than hospital staff in order to 'decrease reliance on senior hospital personnel'<sup>85</sup>, in addition to the training of lay Community Health Workers. At a meeting of the hospital board in August 1980, Hackland commended Drs Prozesky and Draper for their work which, he pointed out, 'was now well known through the country'.<sup>86</sup>

Yet during the development of these strategies in the 1970s, as I have shown, they were continually compromised by funding problems, and whilst clinics did receive some financial support, they struggled, at times, against the government's prioritising of curative, hospital-based treatment. This was particularly evident in the case of the new Manguzi Hospital that was developed immediately prior to takeover, which I now briefly describe.

In 1979, R1 million was provided for the development of a new, larger hospital at Manguzi. Three years earlier, when proposals for this were being formulated, the medical superintendent Dr Allwood made known his opinion on the matter:

I think the establishment of a huge hospital at Maputa is an ill conceived idea. While certain improvements in our present facilities are clearly needed, the present communication problems and fairly small population hardly make this the place for the proposed 300 bed hospital.<sup>87</sup>

A year later he pointed out the unnecessary demands that a new hospital would place upon the staff, and his strong preference for a community-centred approach:

Our concern is that this [new hospital] would unnecessarily increase building and running costs. It would also be a drain on manpower and effort once in use. We also felt that it would commit the staff to a more hospital centred medical care. It is generally agreed that in our area a more community centred medical care should be evolved.<sup>88</sup>

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<sup>84</sup> Bethesda Hospital report, 2<sup>nd</sup> Aug 1980. CLHR. MS19 099.

<sup>85</sup> Manguzi Hospital annual report, April 1979. CLHR. MS19 099.

<sup>86</sup> Minutes, Manguzi Hospital board meeting, 2<sup>nd</sup> Aug 1980. CLHR. MS19 099.

<sup>87</sup> Manguzi Hospital report, 4<sup>th</sup> Nov 1976. CLHR. MS19 099.

<sup>88</sup> Manguzi Hospital report, 4<sup>th</sup> Aug 1977. CLHR. MS19 099.

Nevertheless, plans went ahead and the hospital was opened formally on 6<sup>th</sup> October 1979, with Chief Buthelezi, leader of Inkatha, delivering an address that attracted a crowd of 2,000. Despite the superintendent's earlier apprehension, the new hospital did bring a status, and more importantly, a significant increase in funding, to Manguzi. Thus over the exciting period of its opening, it was largely commented upon positively in hospital reports. From a position in which Bethesda had been the larger and somewhat more financially secure of the two hospitals, it now seemed to be standing in Manguzi's shadow, experiencing 'critical [financial] difficulties'<sup>89</sup> whilst Manguzi was described as 'entering a new chapter'<sup>90</sup>. However, despite the initial large payment for its construction, and the enthusiasm generated by its opening, by December 1980, Manguzi again found itself with a 'huge deficit'. They were receiving a monthly grant of R52,000, a sum falling nearly R30,000 short of the budget.<sup>91</sup>

A year later, in 1981, attention turned to Bethesda. Dr Hackland reported that the Department of Co-operation and Development had drafted plans to establish a regional hospital of 600 beds at Bethesda. The board received this news with 'great apprehension'<sup>92</sup>, stating that it was 'concerned that development totally unsuitable may take place at Bethesda and at all costs wanted to avoid the situation which is now a fait accompli at our sister hospital Manguzi'.<sup>93</sup> The plan for a regional hospital at Bethesda never came to fruition. Nevertheless, such disputes indicated a repeat of the arguments of the 1940s, in which more radical plans for community health came up against the hospital-centred focus of the state. The fact of an imminent takeover heightened the tensions around this debate, because it was unclear both to what extent the government would continue the community work that the mission had begun, and whether the mission itself could continue medical work in the surrounding district without any longer having control over the hospital. Such concerns were reflected, for example, in the push to achieve official recognition for Community Health Workers at this time, as well as a standardised syllabus for primary health care training for nurses.

However, the biggest concern for missionaries at both Bethesda and Manguzi at this time, once government takeover had become inevitable, was a fear of the

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<sup>89</sup> Minutes, Bethesda Hospital board meeting, 4<sup>th</sup> Dec 1979. CLHR. MS19 099.

<sup>90</sup> Manguzi Hospital report, Dec 1979. CLHR. MS19 099.

<sup>91</sup> Minutes, Manguzi Hospital board meeting, 10<sup>th</sup> Dec 1980. CLHR. MS19 099.

<sup>92</sup> Minutes, Bethesda Hospital board meeting, 6<sup>th</sup> Mar 1981. CLHR. MS19 099.

<sup>93</sup> Minutes, Bethesda Hospital board meeting 15<sup>th</sup> Aug 1981. CLHR. MS19 099.

discontinuation of spiritual ‘witness’. This was expressed by a doctor at Manguzi immediately after takeover:

On a recent visit to a KwaZulu hospital, where the mission had decided to withdraw completely, I was struck by the total change in the place now run by SADF [South African Defence Force] doctors, totally secularized, having major staff problems, I felt a sickness to the depths of my soul to think of Manguzi similarly changed in a few years’ time.<sup>94</sup>

Indeed, such concerns first appeared several years earlier when suggestions of a takeover were beginning to surface. In 1970, staff at both hospitals requested for chapels to be built on the hospital site. This was around the same time – perhaps not coincidentally – that the possibility of a takeover began realistically to be spoken about. Both requests were met promptly and enthusiastically by the Church and the chapels were completed at Bethesda in 1975 and at Manguzi in 1976, perhaps symbolising a reassertion of Christian ‘witness’ and spiritual presence in a space perceived as dominated increasingly by external and secularizing forces. At Bethesda, a ‘Spiritual Affairs Committee’ was set up ‘to look after the Chapel’, also giving a degree of official status to this aspect of the hospital’s work.<sup>95</sup>

In 1981, a ‘Christian Work Committee’ was set up with the aim of furthering the spiritual work of the hospital by drawing on a wider interdenominational group. In the same year a ‘Caring Committee’ was established at each hospital and several months later combined to form a single Committee overlooking both hospitals. Its main functions were to ‘provide spiritual support’ to staff, as well as to assist in seeking Christian doctors and nurses to fill vacant posts.<sup>96</sup> The government, fortunately for them, seemed forthcoming in allowing them to continue spiritual work in the respective hospitals. Indeed, as I explore in Chapter 4, certain practices associated with the hospital’s Christian-centred past persist formally at the hospital today, long after the departure of mission doctors.

Finally, the stated aim of the Christian Work Committee which was emphasised as essential to furthering the spiritual work of the mission was with regard to pursuing – as far as possible – its programme of community health:

[To] channel donations of cash and kind to enable the Staff to continue its response to the needs of the whole Community [and to] guide in establishing ways and

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<sup>94</sup> Manguzi Hospital report, 4<sup>th</sup> Dec 1981. CLHR. MS19 099.

<sup>95</sup> Bethesda Hospital quarterly report, 31<sup>st</sup> Dec 1975. CLHR. MS19 099.

<sup>96</sup> Minutes, Bethesda Hospital board meeting, 4<sup>th</sup> Dec 1981. CLHR. MS19 099.

means of bringing total health to all – for health is harmony of body, mind and spirit.<sup>97</sup>

This quote demonstrates, once again, the way in which deep-rooted missionary theology of physical and spiritual healing is combined with the contemporary language of primary health care, evoking for example the WHO's widely publicised key goal emerging from the Alma-Ata Declaration of 'Health for All'.

This renewed spiritual emphasis, and the way in which the broad approach of community health fit so easily with holistic missionary conceptions of healing, meant that the contest between hospital-based and community-based approaches to health care delivery seemed to take on a spiritual significance, coming to signify for the missionaries a more existential fight between secularism and religious faith, and between the treatment of physical disease and the attainment of spiritual salvation. Thus it was through maintaining a focus on Community Health that the mission could really leave its imprint.

### **Inkatha and Zulu ethnic nationalism**

It is difficult to say whether the nursing staff and other employees at Bethesda welcomed the takeover or not. There are suggestions from the committee reports that during the period of takeover, some nurses rebelled against the mission. At Manguzi, there were complaints that the staff no longer considered their 'Christian responsibilities and responses' as important.<sup>98</sup> At Bethesda, a report described 'a general feeling of antagonism between some of the staff and white families', as well as a 'great concern' that the nurses no longer wished to participate in Hospital Christian Fellowship.<sup>99</sup> Certainly, such indications raise important issues about the use of archival data and its limitations, as they reflect mainly the perspectives of missionary doctors. Marks points out in relation to the ethnic nursing associations that were formed within bantustans, that some nurses in South Africa at this time supported the "Africanisation" of nursing, and that others 'had imbibed the language of ethnic difference, which may have afforded them the possibility of a more nuanced sense of identity and cultural continuity

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<sup>97</sup> Bethesda Hospital quarterly report, 30<sup>th</sup> Sep 1981. CLHR. MS19 099.

<sup>98</sup> Minutes, Manguzi Hospital Caring Committee, 5<sup>th</sup> Mar 1982. CLHR. MS19 099.

<sup>99</sup> Report from Bethesda Hospital & Mission to Total Health care Committee, 27<sup>th</sup> May 1983. CLHR. MS19 099.

than the missionaries had provided' (Marks 1994: 184). Yet overall, she argues, 'black nursing opinion... was overwhelmingly against the formation of homeland associations' (ibid: 184).

The takeover of mission hospitals occurred alongside the intensification of Zulu nationalism in the KwaZulu 'homeland', propagated by the ruling Inkatha Freedom Party (IFP). Much of the literature on Inkatha focuses on the political violence and coercion that dominated urban areas (Maré & Hamilton 1987; Bonnin 2000; Freund 1996) and very little on events in the rural regions of KwaZulu. Ubombo like many rural areas tended to consist primarily of IFP supporters and sympathisers. The enormous political rift caused by divisions between the IFP and the ANC-aligned United Democratic Front (UDF), producing extreme violence that 'escalated into a situation of full-scale war' during the late 1980s, was most acute in the cities and townships (Bonnin 2000: 307). Amongst nurses, there was some mention of fighting in Ubombo, although they spoke only vaguely and often reluctantly about this period of violence that broke out again in the years prior to the elections in 1994. This silence was, in itself, telling. But such a silence means that my comments must remain somewhat speculative.<sup>100</sup>

The most outspoken nurse at Bethesda spoke with a sense of pride about Bethesda nurses' professional objectivity and lack of political allegiance. On one occasion, she recalled, a bus carrying ANC activists was involved in a car crash on the nearby N2 highway. They were all brought to Bethesda, and feared that they would be refused treatment or even mistreated because the area was a renowned IFP stronghold. Yet to their surprise, she told me, they were given excellent care and treatment. Dr Hackland also said that on one occasion, IFP supporters had attempted to hold some form of political rally within the hospital, but they were refused. 'The doctors wouldn't have allowed it!' he explained. It was mainly, he claimed, in urban areas that such political activities affected health care directly. At Prince Mshyeni Hospital in Umlazi near to Durban, for example, health workers refused to treat anybody who did not hold IFP membership. In some areas, government employees were forced to swear allegiance to

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<sup>100</sup> Marks noted a similar difficulty, at times meeting 'a wall of silence' when trying to find out about such issues from nurses (1994: 272, fn.4). Prior to 1994, involvement in political or union activity risked penalisation by the South African Nursing Council. Furthermore, in KwaZulu, not joining Inkatha potentially resulted in violence or dismissal. While these risks are no longer relevant in the post-apartheid period, high levels of political intimidation and violence during the early 1990s did have a lasting effect, generating among nurses considerable reluctance to talk openly about these events.

Inkatha as a condition of work (Marks 1994: 196). Thus Bethesda appeared to have maintained a certain space of autonomy, described by Hackland as ‘a haven’, independent from these political divisions that overwhelmed other regions and institutions.

Yet despite the relative lack of direct coercion, nurses at Bethesda were far from free of political control. Nurses from the bantustans, de Beer explained, were ‘bound to particular ethnic government institutions in a relationship of financial dependency. The bantustan bureaucracy is a very real thing in their lives’, a reality further exacerbated by their forced departure from the South African Nursing Association and subsequent affiliation to ethnic nursing associations (de Beer 1986: 76; Marks 1994: 183-4).<sup>101</sup> As professionals, nurses would have been extremely constrained by the separate development propagated by the apartheid state through the system of independent ‘homelands’. In Chapter 7, I show how international migration offers a radical departure – symbolically and pragmatically – from the profound restrictions endured under apartheid.

As will become clear in Chapter 4, nurses with whom I spoke who worked or trained at Bethesda during this period, on the whole recalled the hospital’s mission days in positive and nostalgic terms, and took great pride in their Christian roots. The ‘mission hospital-trained nurse’, more than anything, emerges as the enduring self-proclaimed identity of that period.

### **A continuing missionary presence and the pursuit of primary health care after the takeover**

Dr Steve Knight, the superintendent of Bethesda from 1980 to 1989, did not recall the takeover as having any great impact on the way things were carried out. They continued pretty much as they had done previously, with the mission still largely in control, in practice, if not officially. Not only did the hospital receive continued support from the Methodist Church, but mission doctors also had considerable influence over the

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<sup>101</sup> Further indication of resistance to ethnic associations is given in the Submission on Nursing to the Truth and Reconciliation Commission (1997) that states ‘Nurses in Kwa-Zulu had resisted forming their own organisation on what they felt were legal grounds’ but the Act was enforced ‘before they could officially contest the issue’ (1997: 28).

KwaZulu government. Dr Hackland himself became the Head of Health Services for the KwaZulu Department of Health. He explained that it was difficult to work with the IFP because of his personal ideological opposition, yet he decided that it was better to work with them, to try to effect some sort of positive change from within. Indeed, he and other mission doctors working in the KwaZulu ‘homeland’ at that time did have enormous influence over the policies and expenditure of the government in the 1980s. Dr Prozesky of Manguzi Hospital, for example, was closely involved in the research and drafting of the Buthelezi Commission report of 1982 which proposed a programme of ‘Total Community Development’ based on the “Prozesky Model” that incorporated the work of Manguzi Hospital as a model for future health care delivery in KwaZulu:

There [at Manguzi] community workers are being utilised as educators and as the first line of provision for simple medical services, and the screening of patients for referral to specialist attention. Tied in with the provision of primary health care is the provision of safe water, and the hygienic disposal of human and other wastes. This in turn links in with the broader issues of community development and rural development (Buthelezi Commission 1982: 420).

Importantly, it criticised the apartheid government’s prioritizing of curative, hospital-based care, stating that ‘whenever there are financial cutbacks... the outlying clinics providing primary health care are first affected, and the hospitals are kept running as far as possible without cutbacks’ (ibid: 393).

Steve Knight explained that Prozesky’s plans became far more feasible under the KwaZulu government than they had ever been under mission control because the financial constraints suffered by the church were more severe, and the later government was extremely forthcoming with his proposals: ‘He [Prozesky] actually convinced the main financial officer of the KwaZulu government to support community health!’ While in terms of the wider South African political economy as a whole, bantustans suffered fiercely from uneven distribution, nonetheless there was a feeling amongst missionaries that their motivations for KwaZulu government funding were effective: ‘We learnt how to shout loudly’, Steve Knight explained.<sup>102</sup>

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<sup>102</sup> Very little has so far been written about the successes and failures of service delivery under the KwaZulu ‘homeland’ government. One interesting exception is a PhD thesis by Wanda Mtembu (2005) that offers a detailed report of HIV/Aids interventions in KwaZulu-Natal before and after democratic elections of 1994. This gives an indication of the important influence of some key individuals during the era of KwaZulu leadership who had worked as doctors at mission hospitals.



He thus claimed that despite the divisive and oppressive aspects – of both the KwaZulu government and the political system of South African ‘homelands’ – that tended to occupy discussions about this period, the KwaZulu government actually had ‘an incredibly innovative group of people working within it’ that meant they could effectively implement fairly radical change. As superintendent of Bethesda Hospital, he reported that during the 1980s, building on the foundations set by Daryl Hackland and his colleagues in the previous decade, considerable advances in primary health care were made, including the development and implementation of the nurse training course.<sup>103</sup> The Bethesda primary health care model was taken up elsewhere, and Knight was invited to meetings both with the Nursing Council and with the Department of Health in Pretoria, in which he was able to advance these initiatives on a national scale. Thus, he said, this was ‘an incredibly exciting time to be working at Bethesda’, pointing out that this depth of influence by a small group of progressive health workers would simply not be possible now. Reflecting on the managerial restructuring that occurred with the change of government a decade later in 1994, in which the role of hospital administration was separated from that of Medical Superintendent, he claimed this had a radical effect over the extent of influence that doctors and other frontline workers could have over the planning of health care delivery:

Hospital service managers came in, and said, “What is this community health programme? What are these environmental health practitioners? These are not supposed to be carried out by the health department.” They really took up the apartheid approach. It was supposed to be the end of apartheid, but they adopted this new device of legislation. Before then the whole thing was doctor based. At that time, I was superintendent, financial administrator, *and* I controlled the clinics.

Thus the wider restructuring of health care services and the re-integration of the separate departments of health into one caused a degree of fragmentation of health care on the local level, which was felt by those working on the front line to be extremely intrusive.<sup>104</sup> Yet from a wider perspective, the reintegration of health services into a single, national health care infrastructure was indisputably necessary and meant that a more equal form of distribution could be worked towards.

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<sup>103</sup> For a journalistic account of the initiatives and projects taking place at Bethesda in 1988, see Murray & Murray 1988.

<sup>104</sup> According to Knight, another source of disagreement and fragmentation during this period was the transfer of primary health care training to the Nursing Council, thus making PHC the sole responsibility of nurses. Charlotte Searle herself was extremely adverse to the idea of training nurses within health centres like Pholela and, as an advocate of professionalization, was determined that the Nursing Council maintain control (personal communication with Shula Marks, 29th Sep 09). Yet some argue that this had the effect of ‘excluding other health care workers from the mainstream of primary care and perpetuating the idea that doctors in the public sector should work in hospitals while nurses provide clinic-based care’ (Kautzky & Tollman 2008: 22). This view was also expressed by Knight as having impacted negatively on PHC at Bethesda hospital, alienating doctors and fragmenting existing practice.

Whilst some suggest, in accord with Steve Knight's opinion, that the establishment of PHC in South Africa was 'explicitly born of the struggle against apartheid' (Kautzky & Tollman 2008: 22), others argue that it had a depoliticising effect. De Beer claims, for example, that the 'community health' approach

...remains trapped within the victim blaming mode of thought... The assumption that people need health education re-inforces the belief that illness arises out of ignorance. Further, the desire to use community development techniques to "help people to solve their problems" rests on a belief that people are unable to solve their problems for themselves, and suggests that the problems are of their own making... But this line of argument ignores the truth that poverty is itself a symptom of a history of dispossession, exploitation and oppression (de Beer 1984: 74).

The idea of radical progress in health care delivery certainly seems somewhat redundant in the context of a wider infrastructure so profoundly unequal in its distribution of resources. Yet, for doctors and nurses working at that time, the level of command that they had over hospital strategies and health care policies generated a powerful sense of control and creativity at the level of implementation. This is to do with a politics of scale, in which the issues facing a small rural hospital, at times, conflict with the problems characterising a wider political economy. To a certain extent, this reflects also the perspective of doctors in contrast to that of managers, whose concerns are engaged with different temporal and spatial scales. This disjuncture between the managerial and the clinical outlook is a key issue in the current context, to which I return in Chapter 5.

## **Conclusion**

In this chapter I have described some of the major themes that were significant in shaping the historical development of Bethesda Hospital. Begun by Dr Robert Turner in 1937, the hospital was run by the missionary society of the Methodist Church of South Africa until its takeover by the government forty-five years later in 1982.

From its inception, the hospital was increasingly subject to the labour structures and health care ideas and policies of the state through various forms of funding and legislative control. Yet this process was characterised by an increasingly chaotic delineation of funding responsibilities between different government departments, including attempts to shift control over to the KwaZulu government, with often

crippling consequences for front line health care provision because of the resultant lack of funds and accountability on the part of the various departments involved. The struggle between the government's push for hospital-centred, preventative care and the mission's focus on community health was a significant area of conflict. It was one that was strongly shaped by wider debates, first during the 1940s when attempts were made to establish social medicine as the prevailing paradigm, and later during the renewed emergence of primary health care as a key strategy within South Africa and globally, during the 1970s and 80s. During this later period, where the apartheid government did support the expansion of clinics, this was often more in word than in deed, reflecting to a large extent its politically strategic, rather than beneficent, motivations.

Yet the state's attempts to enforce control could only go so far. Bethesda continued to provide outreach in the form of clinics, health education and various other projects in the surrounding district that eventually gained support and funding under the KwaZulu government. I have argued that such activities enabled a reinvigoration of missionary ethos through a shared appreciation of holistic care. These initiatives were inspired by the international shift towards primary health care and the emergence of organisations such as the National Progressive Primary Health Care Network that facilitated and supported a range of PHC interventions across South Africa. This wider context was significant in the years leading up to takeover, providing new impetus to the mission's pursuit for community health and, in turn, giving renewed significance to the missionary ethos. The government's chaotic and inefficient involvement coincided, therefore, with a resurgence of creativity and energy on the part of the mission, even despite imminent takeover. Hence both the spiritual and community health aspects of the hospital's work were seen, together, to be the most important activities for continuation after takeover. Whilst rural health care during this period was vastly inadequate to meet the immense needs of the surrounding population, the advances made by the Methodist mission in establishing clinics in the district was an important contribution, constituting the infrastructural basis of current primary health care provided by Bethesda Hospital.

An intriguing issue that emerges from the material presented in this chapter is the hospital's relationship to its wider social, political and spatial context, seeming to be, in different ways, both separate but also integrated within it. Nurses experienced this separation explicitly while training at Bethesda during the mission period: heavy

restrictions were placed on them leaving the hospital such that only for specific purposes were they allowed. Furthermore, the acculturation they gained through training set them apart socially from the broader milieu (cf. Cheater 1972; 1974). But this external community was one to which they were inevitably tied, to a greater or lesser extent, through shared cultural, racial and linguistic markers. It is this ambiguity and its manifestations in the contemporary context to which I turn in the next chapter, in an effort to locate Bethesda Hospital and its employees within their present social and geographical locale.

## Chapter 3

# Traversing boundaries: the ambiguous roles of nurses within and beyond the workplace

### Introduction

In this chapter, I turn my focus to nurses in the contemporary context of Bethesda Hospital, considering in what ways they see themselves, and are seen, as part of - or distinct from - a wider social setting. I look at how nurses occupy roles of friends, neighbours and kin in addition to those of professionals and state employees, and describe the ambiguities and struggles that arise as a result. In doing so, this chapter attempts to situate the hospital itself in its broader rural context, looking at the ways in which it is positioned both within, yet separate from, the area which it serves. One central contention is that the spatial spheres of the inside and outside of the hospital serve as a symbolic index for two separate yet interlinked social realms occupied by nurses, and for the contrasting roles that they assume, as ‘public servants’ and ‘private citizens’ (Gupta 1995).

I begin with two short accounts told to me by nearby residents and hospital users, which provide a useful vantage point from which I later analyse nurses’ own views. I start here because the representations of nurses within these stories share many features with wider public perceptions and, in this sense, are more ‘visible’ and pervasive than the situated and multifaceted views held by nurses themselves.

The first was told to me by Noreen,<sup>105</sup> aged 35, who lives in the village of Nkangala, a short drive away from the hospital. At the time of research, she was unemployed and looking for work, selling mobile phone credit informally in the meantime to get by. We were driving to town, after having dropped in to visit a nurse, Grace, who lived near to her, and she told me: ‘The teachers and nurses think that they are better’. I asked her what she meant and she recalled an incident that had taken place at the hospital

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<sup>105</sup> A pseudonym. Apart from mission doctors named in the previous chapter, I have used pseudonyms for all informants.

involving Grace. Noreen had taken her son to hospital and had waited for a very long time in the queue to see the doctor in the Out-Patients Department (OPD). When they finally saw him, he referred them to the physiotherapist. She took her son immediately to the physiotherapist who treated him and told them to return again to the doctor. On their return to OPD, she saw Grace who had been working there all morning. Given that she had waited for such a long time earlier that day, she asked Grace, “Do I have to wait in the queue again, or can I go in to see the doctor when someone comes out?” Grace replied, “No, you must go and wait in the queue.” So again they had to join the back of the queue and wait for a long time. ‘She didn’t help me even though she knows me!’ Noreen said in an annoyed voice. But while they were waiting, another nurse acquaintance of Noreen’s, who also lives in Nkangala, saw Noreen and said, “*Hawu!* You have been waiting all morning. You mustn’t wait again. Come with me, and you will see the doctor now.” She sent Noreen to the doctor as soon as the next patient came out. ‘You see? She helped us, because she knows us. She is only a staff nurse, but yet she helped us. But Grace is a professional nurse and she wouldn’t help. It is because she likes to be better’. I asked Noreen whether she found that nurses in the hospital behaved in this way generally. She replied: ‘The thing is that I *know* her. So I can see it more with her’.

It was not that she had to wait twice to see the doctor that, in itself, made Noreen angry. Rather, as she emphasised following my question at the end, it was the fact that Grace failed to provide the help that she felt entitled to on the basis of knowing her outside of the hospital context. For Noreen, an expectation of reciprocation and social obligation was undermined by Grace’s refusal to help. The fact that Sibongile, despite being ‘only a staff nurse’, was able to help her, demonstrated to Noreen that Grace was not compelled by the formal regulations of her work to send her to the back of the queue. Rather, she had refused to help in order to assert her status vis-à-vis Noreen, ‘because she likes to be better’. Noreen’s interpretation was supported, she claimed, by Grace’s general attitude of self-importance and social distance that she displayed in relation to Noreen and others in the village.

Thus Noreen had an expectation of favour from Grace on the basis of ‘knowing her’ in the village context. She anticipated that Grace would honour their social connection by allowing her to the front of the queue. By not doing so, Grace reinforced her position as a professional and consequently undermined her private relation to Noreen. Noreen

subsequently rejected Grace's implicit claim to superior status in the village context, saying, 'She behaves in this way yet she does not even have a nice house. It is so dirty inside'. Thus, having been unable to challenge Grace's assertion of professional status in the hospital context, Noreen attacked her most powerful symbol of status and respectability in the village: that of material possession.

The second account was told by Busisiwe, the daughter of a professional nurse at Bethesda, regarding a traumatic experience she had had as a patient at the hospital five years ago, in which the presence of her nurse/mother had saved her life. After giving birth to her son, the nurses gave her drugs regularly to control the pain. They gave her a shot of methane, but she had a severe allergic reaction to it. She explained how she had felt her breath getting shorter and shorter as she became increasingly tired and extremely hot. She didn't know what was happening. The lights were out and, she said, 'all the nurses were just sitting somewhere, sleeping'. Eventually, she said to her mother who was on duty that night, 'Open the window. I'm too hot'. Her mother was shocked because the room was cold. 'I could feel that I was dying, and I said, "Ma, I can't breathe properly"'. Her mother turned on the light, and saw straight away what was wrong with her. She went to the cupboard and prepared an injection. By this time the other nurses were stirring and asking what was wrong. Busisiwe's mother injected her, and straight away, she could feel herself recovering. She told me, 'It was lucky that my mum was still there, because she was about to leave. If she hadn't been there, I wouldn't be here now.'

In this story, it was upon the kin relation between Busisiwe and her mother, rather than the professional obligation of the other nurses towards her, that Busisiwe felt able to rely. As in the story told by Noreen, Busisiwe's account suggests that a greater level of care is expected from those with whom one shares a personal relationship outside of the hospital. Yet in this instance, other nurses are also depicted as lazy, unreliable and ultimately neglecting their professional duty to care. In both stories, personal relations provided a central basis for a feeling of entitlement and trust in the medical system even if, as in the first example, this trust is undermined. The second example in particular reflects a deep suspicion felt by many patients about services provided at the hospital, and is just one of many such stories about nurses mistreating patients, that reflect a wider public discourse about nurses.

These examples also introduce a central theme that I develop throughout this chapter: that expectations, tensions and conflicts emerge as a result of nurses occupying ambiguous roles both as professional health workers and as kin relations, friends and neighbours. A recent anthropological literature on street-level bureaucrats and locally situated state bureaucracies has addressed the so-called 'blurred boundaries' between the state and society and between 'public servants' and 'private citizens' (Gupta 1995; Fuller & Harriss 2001). The activities of state institutions on the ground, and of the local bureaucrats that work for them, generate concrete understandings of an otherwise abstract and monolithic concept of 'the state'. It is because the idea of the state is constructed on the basis of local practices rather than as an abstract ideal that, Gupta argues, corruption in India is perceived as a fundamental aspect of state procedure, rather than as dysfunctional to it (1995: 376). Such arguments rest upon an important distinction outlined in Philip Abrams' seminal article, between the 'state-system' – an actual conglomeration of institutions and individuals – and the 'state-idea' – an ideological and political concept (Abrams 1988).

Gupta & Ferguson (2002) focus on the tension that this creates, as the familiarity of local state practices and employees challenges the central ideological component of the state-idea, that it is distantly located and 'above' grounded contexts:

Village-level workers, in particular, represented an interesting paradox. On the one hand, their presence in the village made it more difficult to sustain the image of the state standing *above* civil society and the family; on the other hand, as marginal members of the state apparatus, they provided a concrete example to other villagers of the verticality and encompassment of the state (ibid: 985).

It is, in particular, those ambiguously placed employees, at once local residents *and* state representatives, who personify the permeability and fluidity of the state boundary.

Nurses in South Africa occupy a similarly ambiguous role, but in general this has been analysed in terms not of a state-society boundary, but rather a division between class groups as nurses aspire towards elite status. This has been discussed in the literature partly in terms of the relationship between nurses and patients, in which two contrasting representations resound. The first sees nurses as sympathetic and compassionate, sharing in the cultural milieu of patients in contrast to doctors who are culturally separate. The second more common representation, in contrast, focuses on the status



aspirations of nurses, and their attempts to separate themselves socially from their patients. I describe both of these briefly in turn.

South African nurses are described by Digby & Sweet as role models and ‘culture brokers’ rather than as upwardly aspiring and socially superior (Digby & Sweet 2002). Nurses play an important role in mediating between the local communities of which they are often part, and the doctors that usually cannot speak the local language. Communication and outreach is therefore one of the most important aspects of nursing. Often this involves the translation of local ways of talking about ill health into bio-medical terminology, and therefore entails an understanding of local idioms of illness and healing. Critiquing the notion that the missionary education of nurses served purely to distance them from the beliefs and lifestyles of their communities, Digby and Sweet suggest that the process was a kind of ‘cultural osmosis’ characterised by a gradual interchange and flux of cultural idioms. The nurse became more effective not by distancing herself from her patients but by being ‘both in and of the local community’ (2002: 121).<sup>106</sup>

In contrast, both in the popular media and in much academic writing on the subject, South African nurses are depicted as driven primarily by a desire for high status that underpins a condescending and superior attitude towards their patients, sometimes resulting in abuse or neglect (Jewkes, Abrahams & Mvo 1998; Segar 1994; Walker 1996; Walker & Gilson 2004). This ‘professional arrogance’, it is argued, has the effect of distancing nurses from their patients and creating a communication barrier between them (Rispel & Schneider 1991:122). Describing the deeply hostile relations between nurses and patients in a hospital in the Western Cape, Jewkes *et al.* sum up the feelings of vulnerability, bad morale, alienation from the community and overwork that nurses described as justifying their cruel behaviour towards patients: they ‘are thus engaged in an unremitting struggle to claim a status and respect as a middle class profession within

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<sup>106</sup> The idea of the nurse as mediator between the patient and doctor is recognised in the wider literature on nursing beyond South Africa. With reference to nursing in the UK, Jenny Littlewood discusses the role of nurses as negotiating health and care by translating patient concerns into the doctor’s professional signs and vice versa (Littlewood 1991: 184). Jan Savage gives a detailed ethnographic account of the ways in which ideas of ‘closeness’ between the nurse and the patient forms part of the process by which the nurse creates a closed sphere of knowledge, from which the (male) doctor and other medical professionals are excluded. Physical and emotional ‘closeness’ to the patient therefore becomes a form of political behaviour (Savage 1997).

environments in which political, professional, historical and personal factors continuously undermine this claim' (Jewkes, Abrahams & Mvo 1998: 1792).

Attempting to account for the differential treatment of patients by health workers in a hospital in Ghana, where a similar perception of nurses prevails, Helle Max Andersen (2004) argues that rather than revealing a *failure* of professional standards, the apparent mistreatment of some patients is facilitated by the very structure of bureaucracy itself. She justifies this claim by arguing that the bureaucratic hierarchy, based upon differing levels of medical knowledge and education that correspond to a wider societal stratification similarly demarcated according to differing standards of education, perpetuates the categorising of patients in a manner that justifies their variable treatment. As educated, elite members of Ghanaian society themselves, it is argued, hospital staff 'favour those patients who are educated, rich and influential, and pay less attention to poor, uneducated patients, who are considered as having low social status' (ibid.: 2007). Such differentiation is justified not only by health workers' assumptions about social status in the wider society, but also by the institutional setting, in which 'the monopoly of medical knowledge naturalizes the professional authority of health workers over their patients' (ibid.: 2009).

Andersen's argument is useful in as far as it highlights some important themes including the intersection between medical hierarchies and wider social stratification, rejecting the idea that rational bureaucracy somehow generates a sealed, 'culture-free' zone (ibid.: 2003), devoid of the social discriminations that prevail outside of its boundaries. Yet whilst claiming that health workers categorise people according to two 'stereotypes', the 'educated' and the 'villagers', Andersen proceeds to apply the same concepts as analytical categories, stating that 'health workers belong to the *educated elite*' (ibid.: 2007, Andersen's emphasis). Furthermore, although she highlights the hierarchical nature of the medical profession as integral to her argument, the analysis conflates all health workers under this broad category, attributing to them shared perspectives both about their patients and about the wider social context. Health workers appear to have fixed identities that are drawn upon unambiguously and unchallenged as a means of asserting control, without sufficient explanation as to how these are formed and how they are socially regenerated, or undermined.

The article by Jewkes *et al.* (1998), mentioned above, provides a more nuanced account to explain the mistreatment of patients by nurses, focusing on the multiplicity of reasons for their behaviour, including aspects of workload and work process, professional culture, as well as wider historical and social factors. Yet their account still seems to lack counter-examples, such that nurses emerge as uniform in their behaviour and mistreatment of patients. This may be to do with the urban setting that they describe, appearing in much of the literature as considerably more politically fraught and divisive than comparable rural hospitals (cf. Von Holdt & Maserumule 2005). At Bethesda, mistreatment of patients was neither as severe nor as widespread as the situation they describe, and there existed much greater variety of perspectives and behaviours constituting relationships between nurses and patients. Whilst some nurses demonstrated indifference and neglect towards their patients, others were compassionate and hardworking.

Thus rather than contradicting each other, the two representations of nurses that emerge from the literature most likely reflect a diversity of situations that are contingent upon particular contexts. Indeed, they arguably occupy points along a continuum, one that emphasises social *distance* between nurses and patients and the other focusing on the *affinity* between them, in contrast to doctors. Seemingly in conflict with one another, they together grasp the ambiguities of nurses' positions as they move between their role as state employees and private citizens, superior professionals and local residents. Rather than characterising nurses as one or the other, this chapter will investigate these apparently contradictory features as ambiguously co-existing, focusing on the considerable variability and changeability of such factors as well as their consistencies.

In this chapter I draw upon data collected not only at the hospital but in the nearby village of Nkangala, in order to explore the wider social networks and relationships in which nurses are involved. This enables the analysis to move beyond the nurse-patient relationship, to consider a wider set of issues. In this setting nurses are kin members, neighbours, and friends as well as being employed professionals and state representatives. I consider to what extent the status of nurses is to do with being a state bureaucrat in a role that has historically been closely associated with respectable middle-class lifestyle, and what extent is it to do, simply, with having a (semi-professional) job, in a context of severe unemployment. The chapter also continues to

explore the hierarchical relationships *between* nurses, because these affect the way in which individual nurses view themselves vis-à-vis others, and avoids the problem of lumping nurses together into a unitary group with a single outlook.

### **Accounts of two nurses**

I begin by giving two accounts of individual nurses at Bethesda, each with different experiences and outlooks but whose opinions converge around certain issues. In the following accounts, based largely on individual interviews with each of the nurses, I identify the extent to which nurses include themselves within the wider community served by the hospital, or whether they see themselves as separate from it, and if so, for what reasons.

Thandeka is a 32 year old staff nurse. She previously worked at the nearby Mosvold Hospital for two years and, at the time of fieldwork, was a student at Bethesda nursing college pursuing the first year of her two year further training to become a registered nurse. She had a young child who lived with her mother in Vryheid, a town about three hours away by bus. Thandeka stayed at the hospital for her training, usually visiting her son about once a month although she wished she could see more of him. When she finishes her training and gains some experience as a registered nurse, she would like to specialize either in theatre or as an Aids coordinator, feeling that these are the two areas that suffer most from staff shortage: 'At my hospital [Mosvold] there is an HIV coordinator but only one... If maybe the staff can be increased, people won't die because of this'.

This concern about the Aids epidemic emerged repeatedly during the interview. When asked why she decided to become a nurse, she said, 'I like to work with the community... helping people, because so many are sick, especially because of Aids—they are too sick... When I come in the house [after work] I am so tired.' She followed this by telling me, without being prompted, about her impressions of some of the problems associated with HIV: 'Because of the social problems here in KZN [KwaZulu-Natal], we have our troubles. It means that people are having children like I'm having it [people are having children in a similar situation to that which I was in]'. By referring to her own situation as exemplifying a broader trend, Thandeka positioned

herself within this wider ‘community’ about which she was speaking, rather than separating herself from it. She acknowledged her own behaviour as a problematic feature of social practice and, by implication, demonstrated that she herself was influenced by the same social pressures, norms and values that affect her patients.

Immediately after this, she made a further comparison between her own experiences and her wider observations about those around her, this time drawing a distinction between the two. In her case, she emphasised, the father of her son died, but in other situations that she has observed, ‘the father is dumping child, dumping mother – I think it’s because of poverty. They have this child and it is too hard – it is hard to show love and they don’t know what love is.’ With these comments, Thandeka drew a connection between individual child-bearing and a broader political economy of poverty, demonstrating an appreciation of the social causes of unwanted pregnancy and ill-health. Yet in contrast to the previous statement, she drew a clear separation between herself and those of whom she spoke, making clear that her own situation was different. She ended these comments by saying that by behaving in this way, ‘I am gaining Aids plus the child [I become infected with HIV/Aids in addition to conceiving a child]’. Ambiguously spoken in the first-person singular pronoun, the tone of this final comment suggested that she was speaking on behalf of those whom she was previously describing, rather than making an explicit disclosure about her own HIV status. Once again, therefore, by speaking as though it were herself, she expressed a strong empathy with those around her. In these comments, Thandeka switched interchangeably between including and excluding herself from this ‘community’, demonstrating simultaneously a strong association through shared experiences, as well as expressing a claim to the position of external observer, presumably acquired through her standing as a nurse with stable employment. As she said, it is *they* who are poor, and who ‘don’t know how to love’.

When asked about her salary, she responded unsurprisingly: ‘The money is much too little. I am trying to budget, but it is not enough.’ In response to a question asking whether she envisaged a lifetime’s career in nursing she said, smiling, ‘I don’t want to die being a nurse!’ She continued: ‘I am regressing as a nurse. I’d like to be a farmer. My grandfather was a farmer. As a farmer you can earn much more money.’ ‘Really?’ I said, encouraging her to continue.

‘There’s a lot of money in the soil, I’m telling you,’ she said. ‘I think certain types are better than others as well, like chickens. If I can be a farmer concentrating on chickens, I can gain a lot of money rather than staying here.’ She proceeded to switch without pause to another observation: ‘You know there are these women who are selling things, like second hand clothes from outside, from other countries. They are getting a lot of money. Those mothers, they say [to me] “you put in a lot of time and are gaining nothing!” Yet they get two thousand rand per week!’

These comments express a feeling of ambivalence about nursing, that whilst it does enable her to escape the ‘poverty’ suffered by others, there are other significantly more lucrative activities that require less effort.<sup>107</sup> The desire for material wealth therefore is not satisfied by nursing. The comments show that nursing, despite being a semi-professional career, is not the most desirable way of making money. She raised international migration as a further possibility, implying that this was an important way to use nursing to advance oneself, but she had been deterred by various rumours about terrorist bombs and a host of diseases including SARS and pneumonia (from the cold) that, she had been told, were prevalent overseas and that ruled the option out for her. In Chapter 7, I return to the issue of international migration, exploring some of the associations, both positive and negative, that are attached to it, and showing how it offers a level of financial and cultural capital that is difficult to achieve in South Africa.

Overall, Thandeka’s account paints a rather different picture to that described by Jewkes *et al.*, in which an overriding desire for status dominated nurses’ outlooks. As she switches from talking about ‘them’ to an implicit ‘us’, Thandeka’s comments demonstrate an ambiguous, shifting and blurred boundary between herself and her patients. She is sensitive to the concerns of her patients, with whom she identifies on the basis of overlapping shared life experience. So whilst she does express both a certain separation from her patients (not fitting into the category of ‘poor’) as well as a desire for material gain, she doesn’t seem overly preoccupied with a self-image of superiority. The lucrative potential from activities such as farming and the selling of foreign items seems to dampen the status associations of nursing, suggested by the jeering comments of the older women as they enriched themselves through the selling of foreign items.

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<sup>107</sup> This was not the case, however, prior to the 1980s when the profession was considerably smaller and more elitist, and its high status indisputable (cf. Cheater 1972). Since then, with the simultaneous emergence both of a wider variety of career options for women and the proletarianization of a growing nursing workforce, the profession has suffered a crisis, unable necessarily to attract students of the highest calibre as it once did.

The second story illustrates some similar points as well as contrasts. Mrs Makhanya was born and grew up in the province of Mpumalanga where she pursued her assistant nurse training in 1982. Realising that ‘there is no future as a nursing assistant’, she returned to school to repeat her matric (standard school leaving qualification) in order to improve her results so that she could go to university. She went to the University of Zululand to pursue a full four year degree in nursing, after which she worked at various hospitals as a professional nurse before starting at Bethesda in 1997. I asked her why she decided to pursue a university degree in nursing rather than to follow the nursing college route and she explained: ‘You are at a better advantage. You do all the subjects at a degree level. This means I could go straight into a masters now if I wanted to pursue my studies, whereas those who are doing the diploma, those courses are not recognised. If you choose to study further, you must have a university degree’. She explained, in addition, that with the degree course, you gain all the essential qualifications at once (including Basic, General, Midwifery, Psychology and Community), whereas to achieve additional qualifications beyond Basic in the diploma system, you have to take time out of work to pursue your studies. The process is therefore longer and more complicated. But for those who do not have enough money for university education, she explained, this is the only option. At the previous hospital where she worked, she continued, ‘I was the only person from the comprehensive course. Even the matron said to me, “I don’t know how to handle this one!” because I had come from that course!’ She further explained that the initiation of an academic course in nursing in 1986 in South Africa provoked a fierce debate, with some people complaining that nurses would be ‘too educated’; that the focus would no longer be on the practical side of nursing. ‘To me,’ she added, ‘nursing is nursing. You do it with your hands’. Yet despite this apparent affirmation of nursing as a practical skill (as opposed to an academic discipline) she nevertheless demonstrated clearly in these comments a pride in having achieved a university degree, and implied that this has given her a certain status in the workplace, suggested by her recollection of the matron’s comment.

Asked about salaries, Mrs Makhanya said, ‘We are in need of money! We are really struggling here. People look at me and think that I am rich. But I do not even have one cent. I am in debt and we are not getting paid until the 15<sup>th</sup> ...’

I said, ‘Do people think you’re rich because they can see that you’re a nurse?’

‘Yes, and also it is because I drive a car. They think that means I am rich. But it is the cost of that car that has wasted all my money. Now I have nothing...’ She continued: ‘Yet some of the people are very poor. You see those people who walk long distances for water. Some of them walk a long way to go to school, and they are not wearing shoes.’ These comments suggest that Mrs Makhanya sees herself as an upwardly mobile professional, occupying a fairly high class status in contrast to those she describes, in relation to whom she positions herself as a distant and passive observer. By bringing up these observations, she acknowledges her own sense of hardship as relative rather than absolute. Yet she defensively claims that others are wrong to assume she is rich. Aware of a wider popular discourse that views nurses as ‘fat cats’ living comfortably off generous government salaries, she offsets this by evoking the common discourse of complaint about salaries amongst nurses. Thus two rather separate spheres of status and relative wealth are evident from these comments, one that situates the nurse as well-off in the context of a wider, predominantly poor population, the other depicting them as underpaid workers, unrecognised and unrewarded for their long hours of work. This latter image is mostly generated from within the nursing sector itself whilst the former can predominantly be said to represent an external, popular image of nurses.

This suggests that these associations, emerging from a contradiction in the historical development of nursing in which black nurses have been associated with an elite lifestyle even as they are downgraded within their own profession, remain salient in the contemporary context. Even though race is no longer as significant a distinguishing category as it was under apartheid, class has come to play a dominant role in defining the differences between people, in terms both of status and opportunity. One important feature of the current period is the scale of unemployment that, in itself, exaggerates the status differences between those with work and those without. The examples of Thandeka and Mrs Makhanya demonstrate that the status attached to nurses is achieved not only through their professional relationships with patients within the hospital, but also in a wider social context in which jobs are few and far between. In the next section, I describe this wider setting, focusing on data collected in the nearby village of Nkangala. Whilst the chapter lacks space for an exhaustive account, the purpose of the following section is to give an impression of one context in which nurses live outside of the hospital.



### **A wider perspective: unemployment and status in Nkangala**

The village of Nkangala is visible from the entrance of the hospital, situated across the valley, on the opposite mountainside. It is home to a higher proportion of nurses and government workers than other areas. Yet it suffers from a lack of road and water infrastructure, as well as proper sanitation. The local government continues to promise these to its residents although it is yet to deliver. The highest point in the village sits alongside a mountain ridge which marks the boundary of the former KwaZulu bantustan beyond which, and far below, can be seen huge, neat circular areas of crops and further in the distance, but easily visible, the large Jozini dam: a vivid symbol for many of the nearby and abundant resources of which this village is deprived. Many people use the hospital's services on a regular basis: mostly those taking treatment for high blood pressure and diabetes, two health problems that are extremely prevalent in this area.<sup>108</sup>



**Figure 1. A view of Nkangala with Jozini dam in the background.**

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<sup>108</sup> Many people are also using the hospital regularly for HIV treatment, although this was rarely talked about.

Following the considerable expansion of government services in former ‘homeland’ areas of South Africa since 1994, employment at Bethesda Hospital – as nurses, counsellors, cleaners, security guards, drivers, kitchen staff and general labourers - is now one of the largest sources of work in the area, along with that provided by other state institutions such as schools and the police force. With very little private enterprise in this remote rural area, the government is by far the largest local employer. Alternatively, a small number of people have managed to find work as security guards or shop assistants in the nearby towns of Mkuze and Jozini, or as labourers on farms. A much more significant and widespread form of income on which many people rely heavily – often exclusively – is the government welfare system: the elderly pension, child grant, and disability grant. As in many parts of South Africa, government grants constitute a crucial form of income for many families.<sup>109</sup> Some households receive remittances from family members who have moved away to urban areas for work. Many people, mostly those of working age who are not entitled to any form of state benefit, make do with more informal means of generating cash. These include the selling locally of items bought cheaply and in bulk from the town such as sweets, soft drinks, beer, frozen chicken and mobile phone credit, the selling of fruits and vegetables grown at home, the collection and selling of bundled firewood or grass, carpentry, sewing and mending clothes, car washing, selling homemade baskets, bowls and floor mats, food shopping and water collection for elderly and immobile people, beer brewing and selling, walking children to and from school, and petty crime. Such informal economic activities are significant in a context in which very few opportunities exist in the formal job market. Most households engage in some form of subsistence farming, but this is usually minimal, and rarely provides more than a small proportion of household food.

This local economy can be viewed in light of the broader post-apartheid South African context which, according to Seekings and Nattrass, has been characterized by ‘the entrenchment of inequality between a stable, permanent urban working class and a set of marginal classes, some precariously employed, most unemployed’ (Seekings & Nattrass 2005: 33). Such pervasive and structural unemployment is rooted, they argue, in labour-market policies of the 1970s that favoured capital-intensive, rather than labour-intensive, forms of production, and that supported the wages and employment of whites such that black people were often denied even basic education yet increasingly

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<sup>109</sup> In South Africa, roughly ten million social grants are paid out each month. This amounts to about three per cent of the GDP (Nattrass 2007: 179).

outweighed the demand for unskilled labour. Thus the problem of unemployment became pervasive throughout South Africa in the 1980s. The following description, written in 1985, indicates the scale of surplus labour and how this looked on the ground:

At Maluti in Transkei, the arrival of an ISCOR recruiter in 1982 with a requisition for 300 experienced workers brought out over a thousand former ISCOR employees; an open request for 300 workers in 1978 brought out 4000 workseekers. At Mtetsi in Lebowa, the labour clerk rings a bell to announce the arrival of a new job requisition. When he rings the bell on Monday, 200 or 300 people line up... To protect against a rush of desperate job-seekers, TEBA in Transkei has erected security fences around its offices' (Greenberg & Giliomee 1985: 71).

The authors describe a similar situation in what was then the 'homeland' of KwaZulu: 'Across KwaZulu, even in the immediate vicinity of industrial areas, there are widespread reports of an ever-closing labour market' (ibid: 70).

Since 1994, despite massive spending on health and education, and distribution in the form of welfare grants, the ANC government has failed to redress radically the problem of unemployment which – by the time it came to power – was endemic. In fact, given its focus on strengthening productivity and profits of the formal sector whilst failing to generate policies that encourage the growth of jobs for the unskilled, unemployment appears overall to have risen (Seekings & Nattrass 2005: 27). In the 2001 census, the district of Umkhanyakude measured an unemployment rate of 66.5 per cent. This was the highest rate of all the ten districts of KwaZulu-Natal.<sup>110</sup>

The importance of kin relationships and personal contacts for accessing employment in South Africa has been widely documented (eg. Seekings & Nattrass 2005; Erasmus 1999; Sharp & Spiegel 1985). During the 1980s, some authors argue, 'stratification by ownership of human, social, or other capital replaced stratification by pass law status and labour bureau diktat' (Seekings & Nattrass 2005: 281). Those without such avenues for job seeking would become increasingly excluded from the labour market, as members of a growing, structurally disadvantaged and predominantly rural, underclass. The corollary to this is that job seeking and financial security become closely tied to a moral economy of social relations in which competition is prevalent.

The following statement by a friend in the village demonstrates this well:

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<sup>110</sup> See the government's statistics website 'Stats Online': <http://www.statssa.gov.za>

My cousin is a teacher in a nearby school. She offered me a job there, working as a biology teacher. I told her that I know biology, because I learnt a lot when I did that course as a paramedic. I could teach biology no problem. But then later I found that she had given the job to someone else, without even telling me. She is my own cousin... People are jealous. They are happy when you are not working. That is why I am going to go to Mpumalanga to get a job. I am going to build a nice house *here*, in *this* village. When I have built that house, I am going to get a very nice car, to show them. Just to show them.

This statement illustrates the centrality of networks of social relations – and the reciprocal responsibilities and obligations that link people together within these – for acquiring employment. Here we are reminded of the two vignettes at the beginning of the chapter that showed how social relationships were similarly important for accessing another scarce resource: that of health care. In this instance, as in the earlier story by Noreen who was told by Grace to wait at the back of the queue, resentment is felt when expectations of kin-based loyalty and assistance are evaded or unfulfilled. Hence the examples together reveal a broader moral economy in which relatedness and relative wealth are central to an understanding of individual and social wellbeing, and in which competition and jealousy – particularly for jobs and other resources in a context in which these are scarce and keenly sought after – are pervasive features of relations between individuals and between households. The statement illustrates the social significance of material wealth, revealing a desire not only for possessions but, fundamentally, for a wealth that is *visible*. Items such as a ‘nice house’ or a car stand as symbols of individual success and self-worth in the midst of social and economic stagnation, as was apparent earlier in Mrs Makhanya’s account.

The accusation of jealousy in the statement is significant. Jealousy – *umona* in Zulu – arises as an important idea in much of the classic anthropological literature on Africa (Evans-Pritchard 1937; see also Apter 1993, pp.116-9). More recently, Adam Ashforth (2005) returns to the concept in the post-apartheid context of Soweto, identifying it as key to understanding the relationship between rising accusations of witchcraft and increasing economic insecurity and stagnation. He states that there is ‘a presumption of malice underpinning community life’, one that is expressed primarily in the form of jealousy (ibid: 1). Jealousy is the basis of, and the incentive for, witchcraft; rendering it a profoundly dangerous aspect of social relations, particularly when high levels of material inequality pervade everyday existence and generate conditions ripe for jealousy (or accusations of jealousy) of those who achieve financial success (ibid: 34). In the

above statement, the notion of jealousy is drawn upon to signify this ‘malicious’ side of social life, the partial breakdown of the moral economy and the threat that this poses to social regeneration.

Yet while, on the one hand, expectations of patronage persist within social networks, there is increasingly a conflicting awareness that jobs are – or should be – given to individuals, on the basis of merit. While resentment is often felt when social networks fail to deliver, as we saw in the earlier example, suspicion arises when job success seems to be overly concentrated within certain families or groups. Questions are raised as to whether jobs were obtained through family connections that should have been equally available to all. For example, in Nkangala, there was widespread feeling that the families of the chief and the *induna* (headman), in particular, were especially fortunate in gaining employment. Much speculation, gossip and complaint circulated as to why this should be. Another friend told me:

I heard recently that *another* of the chief’s daughters got a job at the hospital. It’s not fair really... Now the chief has five children that are working. Some are there in the hospital and some work at spa in Jozini. There are nineteen of us in my family and none of us are working. That is why I am leaving. There are no opportunities here. Even the *induna*: six of his children are working! - because there was another one that started working there at the hospital in May. They are the ones that are getting all the jobs... Everyone here is angry about it.

Thus an ambiguity surrounds the provision of jobs, largely supplied by the state, which creates suspicion about the terms on which they are offered. Questions of patronage arise, particularly when powerful members of the community such as the chief and the *induna* seem to benefit as they do.<sup>111</sup> It is through this lens of conflicting feelings of entitlement and suspicion that, I suggest, attitudes towards hospital services – also a form of state provision – can, in part, be understood. The chapter’s opening vignettes contained an indication of this, as patients sought access to health care via those with whom they had a personal relationship beyond that of the nurse-patient, while those who failed to access resources on this basis felt unfairly treated. Importantly, failure to meet such socially-embedded expectations is interpreted as a statement about status differential.

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<sup>111</sup> This connects to a wider literature arguing that systems of patronage feature significantly in African political contexts as a means of accessing power and economic advantage, an argument advanced by Jean-François Bayart who developed the influential idea of ‘reciprocal assimilation of elites’ to encapsulate this notion (Bayart 1993).

## **The situation of nurses in Nkangala**

The post-apartheid expansion of health and education in rural areas has helped to counteract the severity of unemployment to a certain extent by providing jobs – with an explicit preference for local applicants - in these otherwise stagnant local economies that lack private investment and enterprise.<sup>112</sup> The result is that nurses are among the highest income earners in Nkangala and usually enjoy a level of economic security far greater than the majority. In contemporary South Africa, argue Seekings & Natrass, the semi-professional class of nurses and teachers represents a ‘privileged elite’ (2005: 269). Certainly in Nkangala, where class must be seen in relative terms, nurses and other government employees constitute something of a local labour aristocracy. Nevertheless, there remains considerable variability in terms of levels of material wealth even between nurses themselves, due to a number of factors: including wage disparities between different levels of the profession; the period of time that a nurse has been employed; and the varying factors that impinge on the ways in which individual salaries are spent, such as the number of dependents within a family and the existence of other contributing sources of income. This variability is shown by the following examples in which I provide short descriptions of three different households in Nkangala.<sup>113</sup>

### *Household A*

This house is situated in a valley behind the main cluster of homes and away from view. It takes ten minutes to walk there from the road that trails through the main village, down a small, steep path and through long grass. It is a white, cement house, large in comparison to others in the area, but old and in poor condition. Ten people – spread across three generations and including four young children – occupy this house. The father is a minister in a local apostolic church, and both parents are retired so both receive a pension. For a long time, the family of ten were surviving primarily off these two pensions, as well as a small amount of subsistence farming during the summer

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<sup>112</sup> A policy of the Department of Health states that only people resident within the health district of Umkhanyakude may apply for a place in the Bethesda Nursing College and the other colleges within the district. This helps to ensure that nursing education provided in the area serves local residents.

<sup>113</sup> I isolate these examples according the unit of ‘household’ because this is considered locally as a relatively discrete entity and it the most obvious unit that separates groups of people, physically and economically, from one another. The category of ‘household’ can be misleading in the sense that producers and consumers of ‘household’ income do not necessarily reside within its locality. For example, some family members may live away in the town, and some recipients of household income may be staying elsewhere. Furthermore, both the practice of polygamy and the multiple kin ties within a small rural area ensure that many households are economically interdependent. In the descriptions that follow, I try as far as possible to include these wider connections.

months. They also kept several goats. In addition to those living with them, they have two daughters, both nurses, who live elsewhere with their husbands and return once a year for Christmas when they give food or a small amount of money to their parents. The family's situation improved a year ago when their third daughter, Duduzile, was accepted at the Nursing College at Bethesda and began training as a nurse. Students receive an income as soon as they start training, so things began to improve quickly for the family. Her father said proudly: 'She had waited a long time for a job, but last year God helped her'. Since then, they have installed electricity.<sup>114</sup> They have also bought an electric stove and a fridge. They have plans to improve the house, and perhaps to expand the farming. Yet water is still a problem. Due to the lack of infrastructure they rely, like others, on rain water, river water and – occasionally – water provided by the government that they collect from large, communal tanks situated on the roadside. Yet the additional income provided by their daughter has enabled them to make significant investments even in the space of a year. These rapid investments are visible and obvious to those living around them. As my research assistant commented once, 'Life changes quickly, Lizzie. This family used to be so poor. They didn't used to have a thing. But now they are rich. He [the father] is a very lucky man because all three of his daughters are nurses'.

### *Household B*

Joyce lives with her husband, two children and three grandchildren. She works as a staff nurse at Bethesda. Her husband is a builder and her eldest son a clerk. In addition to these incomes, the family receives a child grant for one of the grandchildren whose parents are not working.<sup>115</sup> Joyce was also supporting another of her sons and two grandchildren who live elsewhere. Her husband built their house in 1994, and it is kept in good condition, although Joyce says that they do not have enough money at the moment to extend it as she would like to. They have had electricity since 1998, and own several relatively expensive commodities, including a television, radio, fridge and toilet. The biggest problem, as for household B, is accessing water given the lack of infrastructure. They pay somebody with a car to collect water from a tap behind the hospital, 15 minutes' drive away.

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<sup>114</sup> An electricity infrastructure is installed throughout the village, but very few houses are connected to it because of the expensive running costs. Many households use solar panels which are cheaper to run, while others do not use electricity at all. Individual gas canisters are popular for cooking on small gas stoves. Others cook solely on open fires.

<sup>115</sup> A child grant is only provided for a child whose parents are unemployed.

Before I finished fieldwork, Joyce had just completed her exams for the bridging course which would enable her to become a fully professional nurse. She had been training for the previous two years, and was waiting for her results. With the increased salary she will receive as a professional nurse, she hopes to be able to extend their home. She used to work at the hospital as a member of the kitchen staff prior to her auxiliary training in 1995. During this time, she met a nursing sister who strongly encouraged her to go back to school so that she could become a nurse and 'improve herself'. The sister told her she was too young to be working in the kitchen: 'Even nurses who were older than me used to call me "aunt"!'. So finally, she took the sister's advice, and went back to school so that she could get her matric (school-leaving certificate), and then went on to become a nurse with the help of her friend who has now retired.

### *Household C*

Gloria, who is unmarried, has been working at Bethesda since 1975 as a professional nurse, and has additional qualifications in Occupational Health and Safety, Community Health, Forensic Nursing and Nursing Administration. She lives with her nephew, who works in the pharmacy at Bethesda. Her son is away at university, and her daughter is also away doing a BTec, both of which are funded by Gloria. Born and raised in Nkangala, Gloria moved to this spot and built her house in 1999. Prior to that, she was living nearby with her brother and sister, but she moved in order to start her own home. She lives in a fairly large, painted brick house, surrounded by a garden fence. The front door leads into a small, fully fitted kitchen, behind which is a small living room. The floor is tiled and covered in a thick rug. A large brown sofa and armchair are positioned around a coffee table, opposite a tall set of wooden shelves upon which ornaments and photographs are neatly displayed, as well as a television and radio. It is apparent that she enjoys a level of material wealth unusual in this area. 'To have a house like this is better,' she said, 'although I am still not completely satisfied with it'. Again, water is the biggest problem, although she explained that the large rain water container attached to the side of the house usually provides a sufficient amount. Occasionally she collects additional water from a nearby borehole. She is proud that she has been able to fund her children's education with her nursing salary, but says that she is still dissatisfied with current nursing wages.

It is evident from these three examples that there is considerable variation in material wealth and consumption practices between nurses. There is no clear cut distinction in



terms of living standards between people who are unemployed and those who are permanently employed, or between semi-professional workers such as nurses and lower-skilled categories. A significant reason for this is the fact that individual incomes are often shared between a large number of people. Those with stable incomes often have many dependents. Gloria's household stands out from the others in appearing to be more contained; the recipients of her income are limited to her two children. Yet despite this variability, all the examples do demonstrate a significant *potential* for material gain that is made possible through stable, permanent employment. Even in household A, relative improvement was substantial over the course of one year. Nurses have a level of security for the future that is not enjoyed by many of their neighbours. Thus, overall, nurses tend to be better off and to have better future prospects than the surrounding population: a major factor contributing to their high status. This dovetails in interesting ways with their position as professionals within the hospital. In Noreen's account, for example, Grace's assertion of professional superiority caused Noreen to criticise her symbolic status at home.

Grace was sometimes criticised by some of her neighbours, such as Noreen, for being more reserved than others living in the village, for not always attending important social occasions such as weddings and funerals, and for staying at home rather than visiting friends. For Noreen, this was a sign that Grace considered herself as superior in comparison with those around her, and was attempting to distance herself from them. Yet this was not representative of nurses' behaviour generally. Overall, considerable variation existed in the kinds of lifestyles that nurses chose to pursue, the types of activities that they engaged in, whether or not they chose to attend church and which denomination they attended, or whether they married monogamously in church or pursued a 'traditional' wedding. All of these are features that have, in the past, been significant indicators of elite status, markers of a superior social grouping to which nurses have consciously attempted to conform (Cheater 1972). In this context, the three households described above suggest that nurses cannot easily be categorised within a single class or status group and that considerable variability exists.

The accommodation provided for some staff at the hospital is also variable in terms of size and comfort yet – unlike in Nkangala – this variability corresponds directly to the stratified nature of the workforce. I now turn to a description of this hospital-based

residence, which provides an important counterpoint to the village context just described.

### **Residence as the ordering of social space**

Until 1994, nurses generally had to arrange their own accommodation in the surrounding area of Ubombo, apart from nursing students who were accommodated in the College. This changed substantially when the ANC came to power and funds were allocated for the expansion of health care services in rural areas, which required a more systematic provision of basic amenities for staff in order to improve the retention of skilled hands in these deprived rural regions. The red-brick blocks of accommodation units and houses that now comprise a large section of the hospital grounds – differently sized and styled but homogenous in design – are therefore a relatively new development. This whole area was previously bare and only a small number of houses existed prior to 1994, built by missionaries, and mostly reserved for doctors and their families. There are also now several park homes – small all-in-one units designed for easy mobility. These are ostensibly a temporary measure in the absence of more permanent housing but many suspect they are there to stay.

Rooms and apartments at the hospital are generally allocated according to occupation and skill level. Students sleep in a large, shared dormitory containing about 15 beds. Professional and staff nurses mostly have a single room in single-sex barracks. These are small with a single bed, storage cupboards and a small fridge and electric stove, as there is no shared kitchen. Showers and toilets are shared as well as a washing room with sinks and scrub boards. Specialised clinical staff that are at Bethesda for one year only for their Community Service – such as doctors, dieticians, physiotherapists, occupational therapists and dentists – live in smaller self-contained apartments or sometimes share these with one other.<sup>116</sup> Finally, nursing matrons, doctors and senior managerial staff reside in larger apartments or houses that include a living room, a fully equipped kitchen and two or three bedrooms. If they decide to stay longer than the period of their community service, they will tend to be upgraded to a larger residence.

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<sup>116</sup> Community Service is a one year programme that doctors and other clinical staff must fulfil after they complete their training, in order to be eligible to work in South Africa. This scheme is to insure a minimum of staffing levels in all hospitals, particularly those in more remote, rural areas that otherwise fail to attract sufficient numbers of staff. Following the Nursing Act (No. 33) of 2005, Community Service has recently been introduced for nurses also.



**Figure 2. Hospital accommodation area.**



**Figure 3. Hospital accommodation: doctors' homes.**

Overall, roughly half of the staff at Bethesda is accommodated by the hospital. General labourers, security staff, kitchen staff and other unskilled workers and a number of nurses are employed from the surrounding area so live close enough to stay at home. Housing is reserved mainly for skilled staff who have moved far from their homes to work at Bethesda. Some assistant and staff nurses apply for residence but are unsuccessful, even if their homes are far from the hospital, because there are not enough rooms for them. These nurses have to seek accommodation outside of the hospital. They are not given priority for housing, the Hospital Manager explained, because they do not fall under the 'scarce skills' category. At the moment, she told me, there was no dietician. They had to keep a space for this post, because if somebody applies and there is no accommodation for them to move into, 'we will lose them'. It was necessary, therefore, to keep some apartments vacant: 'Without doctors we cannot function as a hospital. Without registered nurses, we cannot function. But we can function without nursing assistants'.<sup>117</sup> This prioritising of senior employees occasionally caused dispute and resentment amongst more junior staff, for whilst some housing stood empty, reserved for skilled clinical staff whose posts are yet unfilled, other junior staff struggled to find a place by themselves. The Hospital Manager explained this as follows:

The problem is that with a staff of 600, you cannot possibly accommodate everyone. You would have something like a small township if you did that... But people feel that if they work here, they are *entitled* to accommodation. It does not work like that. But they feel that it is their entitlement.

Limited rooms are thus allocated on the basis of occupational position, and variable standards of accommodation represent structurally the hierarchy of the workforce. This resembles a kind of 'company town' model well known in both private and public sectors throughout South Africa. The company town of Kleinsee, whose 4000 inhabitants are employed as mineworkers by the De Beers company (Carstens 2001: 6-7), is a good example. In a context such as this in which a town's residents consist predominantly or exclusively of the migrant workforce serving a particular company or institution, argues Carstens, 'housing, and its cost to the employer, is a significant indicator of each employee's status in the industry, determining and reinforcing the

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<sup>117</sup> In the 'Employee Housing Policy' (July 2004) produced by the Department of Health, 'Nursing Assistant' and 'Staff Nurse' are both included within the 'Scarce categories of Staff' group, to receive first priority. The Nursing Manager – who at Bethesda resides in a large property on-site – is listed in the category labelled '“On-Site” Personnel', to be given second priority. Despite this, professional hierarchy appears usually to take priority in housing allocation.

nature of the relationship between employer and employee' (ibid: 4).<sup>118</sup> Bethesda Hospital has a similar structure, although on a smaller scale. Yet because of the already extremely stratified nature of the medical and nursing professions, it offers a particularly stark example of such occupation-based housing allocation.

Housing therefore has a strong symbolic dimension. At the hospital, it signifies the stratification of the workforce, and in Nkangala, as the previous section demonstrated, it is the most important signifier of status, an obvious form of conspicuous consumption for those who are well-off. However, whilst hospital residence is neatly structured, corresponding exactly to the stratification of the workforce, living arrangements in Nkangala are considerably more variable. This suggests that, despite the historical association of nursing with an elite class, realities are very much more contingent upon individual circumstances. Where salaries are distributed across a broad spectrum of kin, as is often the case, accumulation of wealth may be a very slow process. Nonetheless, in a context of high unemployment, any form of stable work – especially of a professional nature – carries a status with it. Earlier in the chapter, I suggested that nurses occupied two distinct yet overlapping social spheres. These spheres are symbolised powerfully by their spatial dimensions: the inside and the outside of the hospital. The neat, red-brick accommodation buildings are one such signifier. In the final section, I pursue this theme further, looking more specifically at the boundary that divides the two.

### **Traversing boundaries**

The separation between the large hospital territory and its surrounding area is maintained by the efforts in place to preserve and police the boundary between the inside and the outside. Two or three uniformed security guards – female and male – stand and sit at the front entrance, checking the vehicles, particularly those on their way out, for stolen goods. Even hospital vehicles driven by senior staff or official drivers are checked inside the boot and behind the seats, every time they exit the grounds. For those who enter in and out by foot, bags are examined for suspicious or stolen items. The problem of crime and theft is a concern for hospital management. The 'Bethesda Hospital Strategy Plan 2006 – 2008/9' states:

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<sup>118</sup> For an extreme example of such regulation, see Moodie 1994, which gives a detailed account of the compound system in which mine workers resided throughout the 20<sup>th</sup> century: a widespread, repressive and highly controlled form of accommodation for workers in South Africa.

Theft is still a big problem at this institution. The perimeter fence project was prioritized as early as the financial year 2001/02 but it is still to be completed. The result is that the unauthorized entry and exit through the porous fence undermines the hospital's risk management policies.

Yet the fear of 'porous' boundaries does not only apply to the physical divide marked out by the fence. With their particular access to valuable hospital resources, employees are also sometimes seen as a threat. Some of the doctors repeatedly suggested that nurses regularly steal medicines: presumably, they believed, to sell outside to make some extra money. When I discussed this with two junior doctors, one suggested that a system needed to be developed to prevent it from happening, such as ensuring that a doctor signs out all medicine. The other complained that doctors were already too busy, and that this was not feasible. Yet he conceded that some sort of measure had to be taken by management in order to prevent it from continuing. Whether, and to what extent, nurses or any other employees were in fact taking medicine for use outside of the hospital, I don't know. Yet the repeated mention of this by doctors spoke of a broader suspicion about the misuse of hospital resources for personal gain, the permeability of the hospital's resource pool, and the representation of nurses in particular as seeming to occupy this area of indeterminacy and porosity: both as insiders and outsiders. It spoke to a social divide between doctors and nurses, where nurses were seen to operate in an unknown and external economic and social sphere beyond the boundaries of the hospital. Indeed, as we have seen throughout the chapter, nurses continually negotiate between two distinct, yet interlinked, social fields inside and outside of the hospital.

Thus nurses occupy an ambiguous role as insiders and outsiders. This, as we saw in Noreen's opening account, meant that nurses were empowered with a certain control over patients in particular contexts. For patients, the permeability of the hospital's boundaries was also a potential risk, yet this risk took on a different set of meanings for patients than it did for doctors. A friend who lived in Nkangala was comparing the hospital in Newcastle – where she formerly lived – with Bethesda Hospital. She complained that at Bethesda, the HIV clinic is conspicuously situated immediately inside the main entrance. The visibility that this gives to patients, she claimed, is compounded by the fact that the building is small so that there is not even space to wait inside: 'You have to sit outside with your big yellow card, and anyone going past can see you!' At the hospital in Newcastle on the other hand, the clinic is situated on the fourth floor, so you can discreetly use the lift to get there. Of Bethesda, she added:

‘Why don’t they have the clinic down there by TB, or somewhere else, not right by the gate! Even the nurses, they are all talking. If they know you and they know you have Aids, they are all talking about you’. This comment clearly identifies nurses as a potential threat, carriers of information from the inside to the outside. As with doctors’ fears about nurses stealing medicine, nurses seem to represent the threat of passage of valuable resources – in this instance of confidential information – beyond the hospital’s walls.

She also expressed discomfort about the location and size of the HIV clinic, an architecture which, by hindering the privacy and confidentiality of patients, signified a felt indifference by management towards the emotional and social needs of patients. She continued, giving another related example of this lack of consideration: ‘The other thing is those boxes. In Newcastle, they are very clever because they give you the food in Shoprite bags. So everyone just thinks that you have been to Shoprite, whereas here you have to take this big box’.<sup>119</sup> She was referring to the government initiative of providing food to HIV positive patients. At Bethesda, this is given out in large, brown cardboard boxes mostly containing vegetables such as spinach, to complement the normal diet consisting predominantly of maize meal. Once again, this indiscretion shown by the hospital was evidence of an apparent lack of concern for patients’ needs for confidentiality, and demonstrated a wholesale failure by management to take seriously the sensitive issues of disclosure and secrecy that pervade local social discourses around HIV/Aids (Stadler 2003; McNeill 2009).

Hospital architecture – although designed predominantly with a view to the pragmatic needs of the institution – came to embody a social as well as a physical construct, exemplifying to patients this disjuncture between the practical (and minimal) requirements of mass health care rollout, and the more complex socially engendered meanings around health and illness that determined another set of needs for patients themselves. Three months after this conversation, the clinic was relocated to another building which was larger. But it was still by the entrance of the hospital, and although there was a larger waiting area inside, queues often trailed outside the building for lack of space. The move, therefore, was not motivated by a need to address the problems raised in our conversation, but rather to create more space for practical purposes. As potential carriers of information, nurses seemed to signify – once again – the threat

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<sup>119</sup> Shoprite is a large supermarket chain in South Africa.

hidden within social relations. While the opening stories of this chapter demonstrate the entitlements and expectations felt by patients on the basis of social relatedness, this final account illustrates the suspicion that accompanies such entitlement.

## **Conclusion**

As Gupta (1995) argued in the Indian context, state employees occupy two contrasting roles of 'public servants' and 'private citizens'. Fuller & Harriss state that 'the boundary between the state and society... is not only unclear; it is also fluid and negotiable according to social context and position' (Fuller & Harriss 2001: 15). At Bethesda, the overlapping of these two spheres generates feelings amongst patients both of *entitlement* to the resources of the state – on the basis of knowing an employee personally – and *risk* – as nurses enact a permeable boundary through which dangerous information may be transmitted. Here we find the reformulation of longstanding themes in the literature, of social relatedness as a source both of the continuity of social life *and* of acute danger and threat to that continuity, as Ashforth (2005) has described in relation to jealousy and witchcraft.

In this chapter I have also shown some of the different symbolic means by which hierarchical differences come to be indexed, and thus through which this otherwise dichotomous state/society contrast is mediated. Hospital accommodation, varying in size and level of comfort according to the type of worker, is the clearest example of the rigid, symbolic fixing of hierarchy. But examples from the village of Nkangala show that there is a great deal of variation in terms of the material, social and symbolic capital available to nurses. The outlook of nurses is also variable: the examples of Thandeka and Mrs Makhanya demonstrate this, yet they also show that for both, status boundaries are being negotiated and, to differing degrees, defended. The experiences of nurses outside of the hospital context, as these cases suggest, impacts greatly on their self-perception as nurses vis-à-vis their patients.

Nurses' perceived status is perpetuated by several factors, including their security as permanent and highly demanded employees in a context of severe unemployment, and their symbolic position as state representatives, informed by an image of the state as the dominant nexus of wealth (jobs, medicine, grants) which people attempt to access, but



which is separated symbolically as ‘above’ society (Ferguson & Gupta 2002). Nurse status is also informed by the hospital’s missionary past that inculcated the idea of nurses as respectable Christian elite. In the next chapter I turn to this aspect, and examine to what extent it still forms an important part of nurses’ identities. Having considered their roles both in relation to each other and within a wider political and moral economy beyond the workplace, I now focus, more specifically, on the internal hierarchy between nurses, and explore the ways in which a perceived transition from Christian to secular governance is constructed and deployed in relation to current workplace hierarchy and moral concern.

## Chapter 4

# Workplace hierarchy, moral debate and nostalgia for a missionary past

The Out-Patients Department (OPD), located inside the main entrance of the hospital and providing short, individual consultations between patients and doctors, is typically a hive of activity. Patients cluster around the large, glass-covered reception desk in the entrance, waiting to collect their yellow appointment cards. Nurses at the front of the room busily test blood pressure and temperature, and weigh patients. Queues of people sitting on long wooden benches and huddled in the adjacent corridor wait, sometimes for hours at a time, to be called by a doctor into one of the several small rooms lining the wall behind where the nurses are working.

Early in the morning however, it is a different scene. A small number of patients, usually between about five and 20, wait quietly for the day to begin, having arrived early to avoid the queues. At 7 o'clock promptly, all of the nurses working in this department, usually about 20, form a neat line at the front of the room, standing equal distance apart from one another and facing the patients who are clustered together on rows of wooden benches. The line of nurses is sometimes too long to fit in the room, and extends down the corridor, and out of sight. The majority are women, wearing knee length blue skirts, white shirts, stockings and black shoes. They are distinguishable from one another by the epaulettes that indicate their level of training. These are small, rectangular, metal bars fixed above the shoulder, enamelled in various colours, amongst them red for general nursing, green for midwifery, blue for psychiatry, white for nursing tutor. The male nurses, of whom there are usually two or three, are wearing black trousers and white shirts. Students stand out in plain white dresses with no epaulettes.

The session begins with a song, which is usually pioneered enthusiastically by two or three of the older nurses, stalwarts of the hospital who have been working there for many years. They sing loudly with harmonised voices, often accompanied with clapping, or swaying two and fro. The behaviour of nurses during these sessions is extremely variable. Some are enthusiastically clapping and dancing, their voices heard over all others, whilst others – often the younger staff nurses – stand slumped against the wall behind them, reluctantly mumbling the words of the song, or stand arms folded, not singing at all.

After the singing of one or two songs, one of the nurses addresses the audience in Zulu, saying a prayer or short sermon, or telling a biblical story, which is then followed by spontaneous prayers muttered individually by all present, both nurses and patients. This simultaneous and communal praying merges together to create a soft hum of sound, intermittently broken by an animated shout or drawn-out wail. This lasts for a minute or so, tailing off until the final couple of voices peter out. A short pause is usually followed by another song.

After this, one of the nurses who steps forward towards the seated patients with a typical greeting of *Sanibonani* ('Hello') and *Ninjani?* ('How are you?'). This direct and conversational address sets a more informal atmosphere, marking the beginning of a distinctly new section of the event. The nurse then introduces a topic related to some aspect of health or hospital legislation. Topics that have come up repeatedly, for example, are procedures for seeing a doctor, awareness of patient rights (*amalungelo*), how to fill in a complaint card, how to recognise common TB

symptoms, and how to prevent mother to child transmission of HIV. The nurse will present the basic issues relating to the topic, and will sometimes encourage the patients to participate by asking questions. In one particular session I attended, a nurse was discussing the concept of 'patient rights' (*amalungelo*). She was explaining to patients that they are entitled to complain if they feel that they are not receiving correct or adequate care. For example, if a nurse is shouting and treating you badly, she tells them, you have the right to report it. Or if you don't want to sleep in the hospital the night before a transfer, you are permitted to raise the issue with staff and to request another place to sleep.<sup>120</sup> She went on to explain that they could do this by speaking with a senior member of staff such as the ward sister or matron, or if they are unsatisfied with an aspect of the service, they could fill in a complaints card. She then described where these cards could be found, how to complete them, and where to submit them.

During this pedagogical exercise, the other nurses wait, motionless in the line until the lesson is complete, at which point they break away, and a hum of chatter and laughter begins as they gather in another room to begin their regular morning work meeting.

## Introduction

An habitual feature of daily life at the hospital, the morning prayer session demonstrates the way in which Christian song and worship are constituted as part of normal hospital routine.<sup>121</sup> Daily prayer sessions have been conducted since the first days of the hospital's existence under mission leadership, and have the feeling, therefore, of evoking this earlier period in an otherwise drastically changed context of health care delivery, in which new forms of governmentality centred on liberal democratic concepts such as 'rights' have come to the fore. Modelled on the missionary principle of amalgamating religious worship and health education, the morning prayer session is a clear link between the mission history described in Chapter 2 and the contemporary setting. It thus offers a fitting point of departure here.

As the description shows, the session is broadly structured into two parts. The first contains singing and prayer, and the second is intended to teach patients either about important health-related issues such as preventative health methods, hygiene and recognising symptoms for common diseases, or about hospital procedures, for instance how the OPD department is organised, or what patients must do on arrival. These two

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<sup>120</sup> When a patient requires a consultation or operation that is not provided at Bethesda, they are transferred to another hospital. Buses leave early in the morning for transfers, so patients often have to spend the night waiting in the hospital because they live too far to travel early in the morning when public transport is unavailable.

<sup>121</sup> Despite the Methodist origins of Bethesda Hospital, the prayer session is non-denominational and broadly inclusive: nurses and patients represent a plurality of Christian practices and affiliations outside the hospital. Further to this, the practice of morning prayers is specific neither to Bethesda nor to former Methodist hospitals, but takes place in some form or another in many hospitals across South Africa.

spheres of knowledge, medical and institutional, determine the basic aims and agendas of the hospital, which are presented to its users as the official line. The event thus resembles a type of ‘institutional display’ described by Goffman (1961: 95), in which language and performance are structured within a formal context that enables institutions to ‘present themselves to the public as rational organizations, designed consciously, through and through, as effective machines for producing a few officially avowed and officially approved ends’ (ibid: 1961: 73). The event is not only pedagogic in content, therefore, but also entails a subtle process of cultivating trust in the authority of the institution. A nurse who had worked at Bethesda for many years was taken aback when I asked her reason for participating in the morning prayer session, and told me that she had always thought that it was ‘compulsory’. Managers strongly encourage, even expect, attendance.



**Figure 4. Nurses about to begin morning prayers.**

The Morning Prayer session at Bethesda reinforces the professional status of nurses vis-à-vis patients because it constitutes a type of performance in which nurses impart their

knowledge, both religious and medical, to the patients. Their uniform, as well as their ordered and formal positions in the room, are visual expressions of this superior status: they demonstrate the embodiment of the nurse's role as a state representative. Yet on the other hand, certain moments of the prayer event seem to temporarily and partially *dissolve* this status difference, most notable the communal singing and simultaneous praying of all present. This is achieved partly through the actual process of singing together and partly through the acknowledgement, implicit within this act, of a shared set of cultural and religious symbols. This paradoxical tension within the prayer session itself reflects the ambiguities of the broader relationship between these two groups that I described in the previous chapter. Nurses are both associated with patients through their role as 'culture-brokers' who, sharing in the language and cultural idioms of patients, carry out an important task in mediating between the doctor and patient (Digby & Sweet 2002). But they are also separated from patients by their professional status. These divergent features of the relationship between nurses and patients, that create a certain ambivalence between them in ward contexts, are expressed in the contrasting elements of the morning prayer session that simultaneously imply both unity and division between the two groups.

The hierarchical relationships *between* nurses are equally evident, visually inscribed by the epaulettes attached to nurses' shoulders indicating their level of training. Furthermore, actual behaviour of individuals during the morning prayer session reveals a subtle interplay of power dynamics that reflect, to some extent, the tensions implicit within the structured relationships between the nurses themselves. Contrasting behaviour appears to be divided primarily along generational lines, as younger, junior staff tend to participate less actively.

The morning prayer session expresses acutely the tensions between representations of 'religious' and 'secular' in relation to the ambiguity of hierarchies in the current health care context. For whilst the nursing profession has, for many decades, been characterised by intense hierarchy, the emergence of new ideologies such as patient 'rights' is generating a self-reflexivity amongst nurses. In the description above, for example, the nurse's talk about *amalungelo* (rights) for example, was not only a lesson to patients, but also served as a reminder to nurses that their behaviour at work is expected to correspond to a meaningful set of codified rules and regulations, and that they may be held accountable for actions that fall outside of these prescribed norms.

Thus nurses can no longer take for granted a superior status in relation to patients, at a time when patients' concerns and opinions are increasingly prioritised, influenced by an ideological shift towards a model that sees patients as 'customers' rather than as welfare recipients. Later in the chapter I discuss how the issue of 'rights' re-emerges in the conversations amongst nurses. Yet rather than being evoked as a means of expressing one's own entitlements, the concept is used as a way of blaming others for purportedly feeling entitled *not* to work. As is the case with religious concepts such as vocational 'calling', I will argue that the secular ideology of rights is also filtered into various blaming discourses in a context of high workload and fears of accountability.

The example of the morning prayer session provides an ethnographic window onto these wider issues that pervade current social commentary at Bethesda, and that I explore for the remainder of this chapter.



**Figure 5. Out-Patients Department**

## **Secularism, rights and generational rift in post-apartheid South Africa**

Described by nurses as a tradition that has continued for many years, the morning prayer session appears as a fragment of the past: an enduring appeal to religious authority yet juxtaposed against a new secular discourse of rational bureaucracy and rights that has marked the historical transition of secularization from mission medicine to state health care delivery. 'Secularization' is here defined as 'the appropriation... by secular institutions of the functions that traditionally had been in the hands of ecclesiastical institutions' (Casenova 1994: 13). It thus refers to an historical process concerning the institution of the hospital, and not to the beliefs and religious practices of individuals as such. With reference to the latter, many authors have pointed out that so-called 'modernity' has been accompanied with a widespread proliferation throughout Africa both of witchcraft/occult practices (e.g. J. & JL. Comaroff 1999; Shaw 1997; Geschiere 1999) and of Christianity (e.g. Maxwell 1998; Meyer 2004; Gifford 1998). This is no less the case at Bethesda where Christianity forms an integral aspect of life for almost all the nurses.

In addition to this empirical process of institutional secularization are the myriad ways in which the idea of secularism has gained ideological currency in various settings. In nursing, for example, secularism has often been perceived and constructed as a threat. For Charlotte Searle – South African nursing academic and educator – the 'dangerous bureaucratic approach... of government-organised service' had an 'impersonal nature' that ignored the emotional, social and spiritual needs of patients (Searle [1968] 1980: 7). For her, the moral and practical well-being and advancement of the profession relied upon 'a philosophy, deeply rooted in the Christian faith, which leads one into nursing and keeps one there' (ibid: 17). In Chapter 2, I showed that missionaries working at Bethesda harboured similar fears about government takeover, believing that secularization, as they saw it, would lead to a deterioration of the quality of health care.

These ideas, based on the profession's historic roots in mission Christianity, have helped profoundly to shape the outlook of many of the nurses working at Bethesda Hospital at present. Yet nurses do not refer to the concepts of 'secular' or 'secularization' in their commentary about this. Rather, as I show later in the chapter, they speak of 'rights' and 'democracy' to characterise the post-mission period. This demands an examination of how these ideas relate to that of secularism. Talal Asad

argues that secularism is an ideological concept that is linked to the 'project of modernity' which, he suggests, 'aims at institutionalizing a number of (sometimes conflicting, often evolving) principles: constitutionalism, moral autonomy, democracy, human rights, civil equality, industry, consumerism, freedom of the market – and secularism' (Asad 2003: 13). It is notable that many of these have emerged as key defining concepts in the post-apartheid era, pioneered by the major institutions of the state such as its health care system.

Harri Englund points out that while the concept of human rights depends for its coherency upon a notion of universalism, its meaning and use can only be understood with a sensitivity to the specific situations in which it is evoked: by analysing the 'translation' of rights as an abstract idea into local idioms, and by examining who controls this translation, and what purpose it serves within a given context (2006: 47-8). In Malawi, he explains, widespread rejection of the ideas of liberalism, such as 'rights' and 'freedom', is often interpreted by local NGOs and churches as symptomatic of ignorance only to be remedied through the provision of civic education. But, he argues, such an explanation fails to account for the 'pluralism of moral ideas' that exists in this context, and for the process of translation that any engagement with human rights inevitably entails (2000: 579). Thus, he appeals for closer attention to such local critiques of liberalism.

By comparing the views of elite and lay congregations of Catholic and Pentecostal churches in Malawi, he identifies two forms of critique based upon differing conceptions of morality. The first, espoused by elite members of the Catholic Church, criticises liberalism on its own terms: based on the principle of 'persons as rights-bearing subjects', they condemn particular economic policies which are taken as an abuse of democratic freedom (ibid: 586-9). Lay Pentecostals, on the other hand, emphasise 'humanity and selfhood as a condition which is acquired through specific actions and experiences' associated with being born-again, which from a human-rights perspective is seen as 'an undesirable shift from this-worldly political and economic problems to a preoccupation with spirituality and personal cleansing' (ibid: 601). Thus within the lay Pentecostal paradigm, Englund argues, a rejection of liberal ideas is based upon a moral conception of unity rather than of individual autonomy.



Similarly, some nurses at Bethesda speak about rights negatively. This discourse meshes with moral debates taking place specifically within the nursing profession to do with a perceived decline of care resulting from the secularization of health services. To this extent, I consider how older nurses draw upon ideas of religious ‘calling’, as well as the liberal notions of rights and democracy, in order to forge a perceived trajectory of secularism in relation to their memories of the hospital’s missionary past and in contrast to current experiences. The idea of historical memory serving as meaningful idiom for current debate is one that has been explored by various scholars of South Africa (e.g. Erlman 1991; James 1999; Scorgie 2003; Stolten 2007). As in Englund’s description in which older people tend more often to associate ‘freedom’ with moral decline, I will show that older nurses’ identification with the hospital’s mission past generates a rift between them and younger nurses who are, in contrast, associated with a new, post-apartheid era.

Several authors have described an emerging generational divide in post-apartheid South Africa, described by Jean and John Comaroff as ‘the burgeoning experience of intergenerational disarticulation’ (J. & J. Comaroff 2004: 337). In response to a perceived crisis realised most harshly by HIV and Aids, and the profound threat that such a disease has posed to the social and sexual reproduction of society, they argue, increasing ruptures between younger and older generations have emerged. For whilst the young bear most responsibility for social reproduction, the entrenched problems of HIV and unemployment undermine and, for many, destroy the possibility for its fulfilment. This is exacerbated by an estrangement felt by young people from ‘traditional’ forms of authority and social structure. Several others have described this generational rift that, in different ways, represents a potential or real undermining of elders’ authority as young people respond to the wider threats of HIV (Scorgie 2003; McNeill 2007) and male economic disempowerment (Ngwane 2004). While based on a rather different context, the situation at Bethesda bears similarities with these studies, in which a perceived moral decline is associated most strongly with, and thought to be driven by, young people. They are implicitly blamed for the stripping away of the Christian ethos in nursing and are held responsible for a moral decline of the profession.

In the remainder of the chapter I discuss several examples of how nurses draw upon religious and secular idioms, respectively associated with the two sides of a historical

transition from mission to state control, and how such ideas ‘index’ wider assertions about contemporary experiences of work and institutional practice.

### **Bethesda Hospital’s missionary past and its relevance in the present**

Mrs Zungu, now a Chief Professional Nurse working at Bethesda, was raised with her two sisters and three brothers in an Anglican mission. Strongly influenced by her grandfather, who was a prominent Anglican preacher, she described her life as having been ‘spent in the ministry’. She began her nurse training in Manguzi Hospital in 1978, in the last few years of its control by the Methodist Church. Since then, she has worked in hospitals in Nelspruit, Pretoria and Nongoma, before finally coming to Bethesda in 1997.

Mrs Zungu explained that in 1977, she had already decided to become a teacher. Yet her plan was interrupted by a vision from God:

I saw that vision in 1977. God said, there will be a time in the future when there will be sick people who won’t [be able to] help themselves. He showed me that vision. I didn’t know that there will be this HIV and Aids.

She realised that God had called her to become a nurse. Years later, when she came to Bethesda, she was first given the job of treating patients with HIV in one of the nearby clinics. She explained: ‘I realised that this was the vision I saw in 1977... I saw that I was really called for these people’. Her Christian faith continued to provide an ongoing source of motivation at work:

You keep on reminding yourself that there is somebody who is looking at you, while you are busy operating, while you are busy talking, or advising the patient... You’re accountable to God as well as to the hospital, in a way. So in my life I just take my patients as God, not as patients as such, but as God. Fear him, respect him, try to do everything according to God.

For Mrs Zungu, then, talking about God offers a way of expressing a deep moral concern about her patients. The idea of being ‘accountable’ to God implies a strong, individual sense of purpose in relation to work, and is expressed by using the current, workplace language of ‘accountability’ – a concept that has gained currency in recent years and that I address in detail in the next chapter.

In her account of how she came to choose nursing as a career, Mrs Zungu drew on the idea of a ‘calling’ from God and, importantly, reframed her experience of this earlier

vision in terms of the current crisis of HIV and Aids. This expression of religious experience and of the past, therefore, was simultaneously an expression of her moral place in the world and spoke to a wider contemporary context. In this section I address some ways in which nurses' memories of the past reflect upon and contribute to contemporary experience. Notwithstanding the multiple complexities of religious experience for nurses, and the myriad 'meanings' of Christian faith for those who participate in it (Tomlinson & Engelke 2006), this chapter is limited to a specific inquiry about the construction of religious idioms associated with the past, and the ways in which these intersect with contemporary workplace debates.

A vast international literature debates the idea of nursing as a 'ministry' and a religious 'calling' (e.g. Emblem 1992; Prater & McEwan 2006; Raatikainen 1997; Widerquist & Davihizar 2006). More specifically, the connections apparent in older nurses' comments – as we shall see - between Christianity, morality, status and professionalism resonate deeply with the history of nursing in South Africa, where Christian faith, 'Western' etiquette and mission education were all indicators of upward social mobility, some of the alluring appeals of a nurse training course that was as much an instruction in lifestyle as it was in occupational skill. As one of the nurses at Bethesda said, 'We used to be institutionalised... We were taught everything, how to behave, even outside the hospital'.<sup>122</sup> The idea of being 'called' to nursing carried with it connotations of benign and quintessentially female goodness – a passion to 'care' – whilst the pursuit of nursing ostensibly for financial gain seemed to undermine the class aspirations of a sector driven by a desire for professional status.

The nurses who trained at Bethesda prior to 1994 when the hospital was still run by mission doctors tended to reflect positively on this period.<sup>123</sup> Older nurses spoke enthusiastically about numerous occasions they recalled: decorating the wards, receiving presents from management and holding big parties at Christmas time, going on trips arranged by the doctors to nearby tourist sites such as Sodwana Bay, gathering regularly for shared meals and barbeques, and invitations to Dr Hackland's home on Easter day; none of which, they were eager to point out, still occurred. One Nursing Manager summed it up, saying that they felt 'that *unity* – initially, when it was still a

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<sup>122</sup> She used the word 'institutionalised' here to refer to a wider process of institutional acculturation during nurse training.

<sup>123</sup> As I explained in Chapter 2, although the KwaZulu government formally took-over the running of the hospital in 1982, it was still run at the local level by mission doctors who continued to have considerable control over the management of the hospital until the change of government in 1994.

mission, we all felt as a family...’ Nurses used fictive kin terms such as this often to describe their relationships with each other during that time. Dr Hackland was described, for example, as ‘a father to us, although he was very strict’ – encapsulating the then patrimonial style of hierarchical management. Work was described as ‘a jolly place’, ‘a hobby’ and ‘good fun’, in contrast to descriptions of work in the current setting that repeatedly emphasised extreme stress, pressure and isolation. Such recollections were intricately bound up with perceptions of the work process then and now: ‘Even on a day off, if somebody needed your help, you would say, “I will assist you, no problem”... Now they say, “Oh, who will give me money for that?”’

Such statements express the sense of nostalgia and loss that is widely felt amongst older nurses when they talk about the hospital’s missionary past, and hint at the feeling of moral disintegration - the breakdown of ‘unity’ - that pervades these narratives. Their accounts are invariable and uncompromising in their appraisal of the hospital’s past under missionary leadership, in contrast to an equally negative portrayal of the current workplace, the two always spoken about simultaneously. Such a strongly comparative discourse suggests that these memories, characterised by an apparently intense nostalgia for the hospital’s mission days, constitute a reconstruction of the past in response to contemporary experiences. As we will see, this representation draws heavily on a perceived shift from a religious to a secular institutional context.

Many of the more senior nurses felt that Christianity no longer plays a significant part in the life of the hospital, a feeling brought more explicitly into view by particular events. In 2006, for example, the hospital manager declared that the hospital chapel would no longer be used for prayer meetings and services, arguing that the space was needed for conferences and board meetings. Since then, the only religious services that take place in the chapel are on special or important occasions, such as a memorial services for members of staff who have died.<sup>124</sup> Just as the chapel was opened – in 1970 – at the significant moment that talk about government takeover began, in order to reassert the centrality of mission ethos at the hospital, so too, its closure seemed to carry a similar symbolic weight. This was clear in conversations with nurses, during which complaints about the chapel’s closure were usually aired in the context of criticisms of hospital management. During these conversations, the event seemed to signify the broader

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<sup>124</sup> Even these services are formalised, official events with programs and speeches by senior staff. In this sense, as with morning prayers, they are structured occasions, arranged by management, that serve a particular institutional purpose.

changes associated with the end of mission medicine and the subsequent bureaucratisation of health care delivery. A chaplain who regularly visited the hospital discussed with me this significant change of recent years, explaining that before the closing of the chapel she used to give regular ‘public addresses’ there, and that these addresses would be heard by all the patients via large speaker systems in the wards. In a similar vein, she went on to recall that she used to take Christian videos to the wards and show them to patients. ‘The patients really enjoyed this’ she said, disappointed that these activities had been discontinued. Her involvement in the wards was now restricted to individual bedside visits. I asked why this was and she explained: ‘With this new democracy, you are not allowed to preach your faith to people. It is against the law. They think it is like brain washing or something’. This statement reveals clearly the feeling that Christian forms of knowledge and authority are being undermined by a ‘new’ type of political power and state control, a shift which is symbolised by the closing of the chapel and its re-use as a conference room.

A nurse who had worked at the hospital since before its takeover by the government explained the way in which Christian practices had changed:

Going to church services is no more a straightforward thing now. You have a choice whether you go or you don’t go. And some of the things that were not allowed before, they are now allowed. You can have a radio in the room – things which were not allowed. So people listen to their radios and if you want to go to church you go. If you don’t want you don’t want... You know, the *rights* – things came with the rights of people to choose.

As with the comment about ‘this new democracy’ made by the chaplain, this statement acknowledges the increasing influence of liberal democratic notions of ‘rights’ and ‘choice’ in calling into question the previously ‘straightforward’ authority of Christianity and the mission. Such examples appear to fit neatly alongside a Weberian model of secularization whereby religion has become a matter of individual belief and choice, diverted to the private sphere, and no longer upheld by the institution itself. Yet this simple trajectory is challenged by the ongoing practice of morning prayers. For whilst the chaplain complained that she is no longer permitted to preach in wards, the example of the morning prayer session suggests that mediums of communal Christian prayer and song still contribute to an institutional agenda, taking a formal and regular place in the daily schedule of wards. Such apparent inconsistency suggests that the process of secularization at Bethesda, in which the individual is posited as the central bearer of ‘rights’ (as emphasised by the chaplain’s account), is uneven and incomplete.

This incongruity may be explained by the fact that, as a ‘political project’ (Asad 2003), secularism is drawn upon selectively when it serves wider institutional aims, yet in the case of morning prayers, in contrast, legitimacy is achieved through the appropriation of religious idioms that are associated with a romanticised past. This selectivity of religious and secular mediums is evident in the fact that both morning prayers and the restrictions placed upon the chaplain are determined by managerial decision-making.

The statements so far indicate that a liberal democratic ideology has become regular currency amongst nurses, drawn upon to distinguish between ‘before’ and ‘now’, and attributed with a certain agency that brings things into effect. As one nurse told me, in an attempt to explain why nursing – as she saw it – had become less disciplined, ‘It is something to do with this democracy, this human rights’. Not quite able to elucidate the connection, yet spoken in a tone that implied that what she was saying was almost self-evident, she drew upon a wider ideological framework as a compelling explanation for the changes felt locally.

I have shown in this section that recollections about the past serve as a yardstick against which complaints are made about the current situation. As such, these conversations have a strategic element to them. In the next section, I argue that in forging their identity in relation to a particular period in the hospital’s history, the moralising overtones of these conversations – the suggestions of moral decline associated with the departure of Christian missionary doctors and the emergence of a new secular, government-controlled era – creates an exclusive category through which older nurses can claim superior moral and professional status, reinforcing an already exceptionally hierarchical labour system in the contemporary context of severe staff shortage and low wages.

### **‘We were having a calling for nursing’: the past as a symbol of morality**

In the process of fashioning a specific, morally imbued definition of nursing based upon their own earlier training and ethos, this section explores how older nurses categorize themselves in contrast to newly qualified nurses, positioning the two groups at different points along a trajectory of moral decline that corresponds to the historical transition from mission medicine to secular state welfare.

The outlook of older nurses is rooted in the concept of the 'calling' which, as we saw in the example of Mrs Zungu, came up frequently as an explanation for having chosen a nursing career and which, with its deep religious overtones, most readily evoked for them the ethos of mission education. In this section, I argue that the 'calling' concept, in part, serves as a device that demarcates an exclusive category of nursing to which senior employees strategically align themselves. This was revealed in a conversation between two older nurses and me as we sat in the small kitchen of Gateway Clinic.<sup>125</sup> Once again we were discussing the changes they had witnessed at Bethesda over the years. One of them said, 'Before, we were having a calling for nursing, unlike today [when] you come for money... People just want to get paid. Because you get paid even to do the training now.' I took her up on this point, remembering that others had told me they received payment for missionary training, under a sort of apprenticeship scheme. She conceded, but declared it was far less than now, shouting out, 'Peanuts! You hardly got a thing!' At this point, the other nurse interjected: 'When I started I remember I only got 87 rand a month!' They both proceeded to laugh and joke about this for a while, repeating the amount with exaggerated astonishment and regaling me with names of small food items that could be bought today for the same amount. 'How are the wages for nurses now?' I asked. 'The wages are good,' said the second nurse, 'they are getting a lot of money now...'

Here, the nurses distinguished themselves clearly from their younger counterparts who, they claimed, were entering nursing for the financial incentive it provides, rather than out of a sense of duty or 'calling'. This contrast was further exaggerated by the comparison they drew between the amount of wages then and now. However, many of the older nurses, in numerous other conversations, have emphasised the importance of salaries as an incentive for having entered nursing, because of the often severe economic hardship of their families and the need to earn money to support their parents and siblings. This suggests that the financial incentive was as much a factor then as it is now, and certainly implies a more complex and heterogeneous set of influences acting on women as they chose to enter nursing. Furthermore, during the very same conversation, the nurses complained about the salaries they received now in comparison to those earned by migrant nurses overseas.

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<sup>125</sup> Gateway Clinic is the first point of access for out-patients. Here they are assessed by nurses and either treated or, if necessary, referred to a doctor for further consultation.

The use of the word 'calling' in this context, and the distinction that it creates between them and younger nurses, is thus a discursive device that enables senior nurses to appropriate power in the work context by claiming moral superiority to which they, having trained under mission education, have exclusive access. The idea of the 'calling' amongst older nurses at Bethesda is also used in association with the contrasting attitudes towards work which these two groups of older and younger nurses are thought to espouse. Another nurse explained:

That aspect of nursing as a calling has diminished. That was important for the old nurses of my time... [Nowadays] if it is time to go off, even if there's a patient who needs service, he'll go. [Whereas] *we* were able to sacrifice...

Younger nurses are portrayed as lazy and uncaring, in contrast to those associated with the earlier period, who exemplify greater willingness to work and, in this instance, to do overtime. She based the motivation for this on the concept of 'calling', deemed to be lacking in those entering nursing today. Once again, then, the idea of nursing as a 'calling' is used as an excluding category, a means of securing the claims of senior nurses to professional status vis-à-vis their junior counterparts.

The idea of the 'calling', with its moral overtones of Christian duty and responsibility, is symbolic of a period in the history of Bethesda Hospital prior to its takeover by the government which led to the secularization and bureaucratization of health services in the region. With this, nurses are seeking ways of establishing and maintaining a sense of professional identity in the face of increasing fragmentation, high work-load, and poor pay and working conditions that have made the already severe and widespread ill health of the population all the more difficult to address from day to day on the wards.

The perceived decline of religious motivation in nursing that older nurses report corresponds also to the emergence of liberal democratic ideas as the backbone of post-apartheid governmentality. One day I was sitting and drinking tea with Mr Dlamini, a tutor from the nursing school. We were discussing the problem, as he saw it, of lack of motivation amongst the students that he taught. At one point he exclaimed, 'it is because of this democracy, this thing of human rights!' I prompted him to explain further and he said, 'They know they are free. They have got their rights now, so they don't care.' He began to describe to me his experiences of growing up on a farm owned by white farmers near to Pongola, a town situated about 40 kilometres from the hospital. He told me he had struggled for his education, because the farmer wanted him to stay



and work on the farm. Each day, he had to sneak away to school when everyone else was gathered in the morning to begin the day's work. Describing himself as 'a product of the old regime', he claims his childhood taught him the values and rewards of working hard. Today, on the other hand, students do not have the same motivations to drive them: 'Now they have their rights, but they are not making use of them!' he exclaimed. He described how he sees 'them' (seeming now to be referring to young people in general) at the side of the road as he drives home from work, drinking beer and dancing. They expect to be admitted into nursing school, he told me, but are not willing to put the effort into their studies in order to 'improve themselves'.

After this, Mr Dlamini returned again to a description of his students' behaviour in hospital. They are often late, he said, or cannot even be found. They don't seem to make the effort to learn or to concentrate, so he finds himself teaching the same things again and again: 'They don't care. They don't like the patients. They don't like the profession. They like' - he paused here for dramatic effect, as if trying hard to think of anything his students liked - 'nothing! They like nothing!' By this point he was smiling and laughing loudly. 'But if they want to ruin their lives, then it is not my *indaba* (concern).<sup>126</sup> It's their *indaba*... But it will affect the patients. That is the problem.' I asked why they would pursue nursing if they disliked it so much. He said, 'It is the money. They do it for the money, nothing else.'

Reference to the concept of 'rights' was common during conversations with nurses as they tried to account for the changes in nursing at Bethesda and for the behaviour, predominantly, of junior nurses. Clearly identifying his students with a particular generational category, Mr Dlamini drew on broader political debates to account for his students' apparent lack of interest in nursing. By associating them with a new, post-apartheid era of entitlement and citizenship - through the liberal democratic notion of 'rights' - he separated himself categorically from them, just as others had done so in the previous descriptions by associating *themselves* with a missionary past. Another professional nurse told me, 'It is difficult to motivate [junior nurses], really, because they're having their rights... It's the new South Africa... Sometimes they're telling you, "that is my right".' She went on to explain that when she asks a nurse to do something, she always has to ask several times. After the third time, she told me, 'they say, "You

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<sup>126</sup> *Indaba* is a commonly used word that has several related meanings including 'news', 'affair', 'item of gossip', 'topic of conversation', 'law case' and 'report'. In the context of this statement it is best translated as 'affair' or 'concern'.

just harass me”... It is this item of harassing; this is in the mouth of everybody’. She continued, drawing an explicit contrast: ‘*They* complain, but *we* did not’.

Another senior nurse told me how things had changed since 1994: ‘Before, I rarely found a nurse sitting on the ward... Things are relaxed now... They’ll tell you of rights; that is how it is now, but I’m not used to that’. She continued, linking this to a lack of discipline that she felt had become the prevailing norm in contrast to the strict training she had received: ‘They are lazy. Even the epaulettes people don’t want to wear anymore. They have them under their jerseys or not at all. But that is not right because as a nurse you must be well identified’.

In the familiar rhetoric of liberalism, ‘rights’ are linked indelibly to ‘responsibilities’. Yet, in this instance, rights are purportedly claimed as justification for *shirking* one’s responsibilities. Furthermore, in this context, people never (to my knowledge) claimed rights for themselves, but only spoke of others’ attempts to do so, as in this example where senior nurses say that their younger counterparts claim recourse to a discourse of ‘rights’ to avoid working and following orders. But my research with junior nurses did not, from their own perspective, reveal this as a motivation. Rather, they tended to express a sense that their work is unnoticed and unappreciated by senior staff and by management, and that their pay is too low, as reasons for why they do not feel motivated to work hard. One staff nurse told me in an interview:

We have to work under stress. Sometimes there are only 3 nurses, with 27 or 22 patients. And all the work is supposed to be done... The matrons don’t say “thanks”. They are always scolding us. They are *always* scolding us!

This frustration when speaking to younger nurses was palpable; they felt that their seniors treated them with disdain and did not appreciate what they did. This feeling was exacerbated by the ongoing problem of low wages, and the fact that the government’s repeated promises to increase them never seemed to come to fruition. At first, such complaints appeared to support the senior nurses’ accusations that a new generation of younger nurses are overly preoccupied with money and lack interest in their work. Yet this moralising attitude had the effect of stigmatising genuine concerns about remuneration amongst staff who, as junior employees, earned the lowest wages. Nurses who criticised younger staff for being driven by a desire for money consistently failed to acknowledge the significant wage discrepancies from which they themselves once

suffered, and now in turn tended to benefit. It is this discrepancy between wages at different levels of the nursing hierarchy that added to the sense amongst junior nurses of being less valued than other employees. One staff nurse for example raised the issue that only fully registered nurses receive the 'Rural Allowance',<sup>127</sup> saying 'so even when it [the hospital] is short staffed, we are getting nothing [extra]. Sometimes there are 20 patients and only three staff, but we still do not get a rural allowance for working here...'. In the previous chapter I discussed the issue of accommodation at the hospital which is allocated according to hierarchical rank such that assistant and staff nurses are given the smallest rooms or are not given a room at all; another source of dissatisfaction for junior nurses who feel they are not equally valued.

The notion of 'rights' – referred to negatively in the context of blame and criticism – thus emerged as a vacuous concept: an expression, perhaps, of a wider disillusionment. 'Human rights' – enshrined as the central tenet of South Africa's radical Constitution and Bill of Rights (1996) – as well as other liberal concepts such as 'democratic participation' and 'citizenship' - have become key tropes of public moral debate in South Africa since the demise of apartheid and the subsequent inception of participatory democracy in 1994 (Chipkin 2003; 2007). Yet, in contrast, widespread expectations of material improvement of basic living conditions have, for many, remained unmet (Marais 1998; Robins 2005). Nursing itself has experienced a similar contradiction: despite increasing emphasis on employment rights, workplace equity, transparency and so on, it is nevertheless characterised on the ground by high workloads, severe staff shortage, poor pay, and labour fragmentation, leading some authors to describe the nursing sector nationally as having reached a state of 'general crisis' (von Holdt & Murphy 2007: 330). This contradiction makes the experience of work all the more jarring, and as Robins predicts, 'this gap between the rhetoric of rights and the economic and socio-cultural realities is likely to continue to haunt social transformation in post-apartheid South Africa for decades to come' (Robins 2005: 2).

Given these contradictions between the optimism of liberal rhetoric and actual experiences on the ground, it is perhaps unsurprising that the notion of 'rights' is interpreted locally in negative terms. Ironically, however, it is those at the bottom of the

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<sup>127</sup> Fully trained, professional nurses receive a financial bonus, known as the Rural Allowance, of 12 per cent of their income as incentive for working in rural areas. The bonus has caused much controversy and resentment amongst junior nurses nationally. In January and February of 2007, hundreds of staff nurses across KwaZulu-Natal (although none from Bethesda to my knowledge) went on strike in demand of a Rural Allowance for all categories of nurses from auxiliary upwards.

nursing hierarchy who are accused of claiming 'rights'. Thus, as we see in the case of senior nurses, the language of 'rights' – appearing to promote values such as 'equality' and 'fairness' at the normative level - translate unpredictably into existing structures of hierarchy at the level of practice and are appropriated by particular groups to defend their own interests in a wider context of institutional accountability, a topic to which I turn in the next chapter.

It is clear that the sentiments that I have described in this chapter, both in relation to nursing as a 'calling' and to the concept of 'rights', speak to a much wider context of political and social transition. Mrs Zungu's recollection of her earlier vision from God that contained a prophetic warning about the HIV/Aids epidemic implied an attempt to reconstruct the past to make it relevant for the present; to appropriate some sense of control and individual purpose in a contemporary social context fundamentally in crisis. Yet, as this chapter has described, older nurses discursively distance themselves from this crisis by associating with an earlier, romanticised period. For them, it is the younger generation who represent the here and now. Consequently, youth are portrayed as 'a potentially implosive source of chaos and criminality' (J. & JL. Comaroff 2004: 339). This view was exemplified in Mr Dlamini's description of young people at the side of the road, drinking and apparently refusing to work, an image which he seamlessly associated with his students in the nursing college. This is similar to the Malawian example described by Englund. He observes: 'Many Malawians... use the term *ufula* ('freedom') for liberalisation gone wild – for an era of insolence by youths against their elders, of an immoral dress code, of disobedience and political disunity' (Englund 2000: 583).

Thus the examples presented in this chapter suggest that moral and professional anxieties generate a rift between old and young: 'new discrepancies open up between the genders and the generations, striking hardest against those most responsible for building a future' (J. & JL. Comaroff 2004: 340). This anxiety was expressed clearly by a senior nurse when she said, 'I always think of my siblings and my children. Older nurses will die. I will die. What will this next generation be?'

## Conclusion

In a context of extreme work pressure, staff shortage and the catastrophic effects of HIV/Aids at Bethesda, nurses seek methods of '(re)gaining control over the signs and currencies, the knowledge and techniques, that permit effective action in the world' (J. & JL. Comaroff 2004: 340). For older nurses, this is achieved in part through the reconstruction of a missionary past. Their nostalgia for this idealised past is evoked in an attempt to reaffirm their own sense of moral worth in the face of the persistent challenges and the inability of the institution or its employees effectively to provide all the necessary care. Yet this carries with it a strategic element, and contributes to a somewhat individualizing rhetoric in which the disintegration and failure of services is seen to be caused by individual motivations, in this case of junior nurses, rather than being rooted in the broader structural inefficiencies of the system or the degree of financial commitment and political will of the higher echelons of government. This same dynamic is subtly addressed and revealed in the formal context of morning prayers, in which the state's objectives are presented without contestation, whilst the embodied performance of nurses speaks to the divisions between them. The maintaining of professional status and of the boundary between senior and junior staff then, is a crucial factor that motivates the actions of nurses in this context.

Yet to what extent is this generational rift an outcome of the wider social transition which is marked by major political change and the onset of HIV/Aids, as J & JL. Comaroff suggest, or to what extent is it due to an *existing* hierarchy between junior and senior nursing positions? Are the generational tensions presented in this paper an expression of rapid social change, or are they a repetition of ongoing conflict not necessarily between generations *per se*, but between different levels of a stratified workplace? Or do the two aspects reciprocally define and reinforce each other? As I indicated earlier in the chapter, those at the higher echelons have frequently laid blame on junior nurses, such as during the strikes of the early 1990s, for apparently transgressing the moral principles and obligations to duty that a nurse is supposed to espouse (Marks 1996: 196). A moral high ground has been sought in the past by senior nurses wishing to separate themselves from the rank and file. In this sense, the contemporary situation at Bethesda reflects a pattern, even as it adapts to new and changing externalities. To a certain extent, the concern with professional status that has always existed in nursing is given new terms for its expression, being mapped on to a

current social situation. Yet at the same time, it comes up against new challenges, with the emergence of liberal concepts such as rights undermining a taken-for-granted hierarchy both between nurses, and between staff and patients.

As Englund shows in Malawi, a discursive rejection of liberal democratic ideas such as rights does not indicate a denunciation of the abstract ideals with which these are associated, such as a free and democratic society. Rather, it reflects the dynamics of local social and political contexts. At Bethesda, senior nurses feel that in recent years, their own authority within an established nursing hierarchy has been eroded by new managerial styles and structures. This becomes associated with a wider societal shift through the idea of rights, which acts to discursively link these two spheres. Part of the motivation for such blaming strategies arises in an institutional context of 'accountability' and 'audit' that serves to exacerbate the emotional strain of excessive workload. Accountability has emerged as a strong institutional principle in recent years and, like that of rights, also carries with it an individualising ethos that sits uncomfortably with the entrenched hierarchies of the hospital workplace. Yet what does accountability mean to people working in this setting? And how does it take shape? In the next chapter, I turn to the workplace itself, to consider how a 'culture of accountability' is formed in the day-to-day interactions of employees.

# **Chapter 5**

## **Paperwork, bureaucracy and the contradictions of accountability**

### **Introduction**

This chapter considers some of the day-to-day practices that are informed by a wider bureaucratisation of government health services in post-apartheid South Africa. In a context in which ‘accountability’ has become a key trope of institutional bureaucracy, I explore the ways in which employees attempt to conform to the normative moral yardstick imposed by ideas of accountability, whilst also expressing a sense of moral uncertainty and discomfort with these. Such feelings are a result, in part, of a contradiction felt by many, that administrative tasks fulfilling the extensive bureaucratic requirements of the hospital are given priority over and above clinical care itself, even in a context of severe staff and resource shortages. This chapter attempts to make sense of this apparent incongruity, exploring the ways in which staff engage with and try to overcome the moral ambiguities and challenges posed by their work.

This central problem is now a familiar feature of health care services the world over. In the UK, for example, excessive paperwork, overbearing and inefficient managerial systems and an associated deterioration of ‘care’, are routine topics of complaint within the National Health Service. The technological advances and complexification of health systems in industrialised regions has produced a vast infrastructure of accountability mechanisms including practice criteria, policy targets, performance indicators and a myriad of surveillance, assessment and evaluation techniques, through which the increasingly patient-centred concerns for transparency, confidentiality and ‘good practice’ are ostensibly realised. Indeed, since the late 1980s, such rhetoric and its associated practices have become pervasive features not only of health systems but of the whole spectrum of public institutions and private companies generally, a phenomenon described by Michael Power in the UK context as the ‘audit explosion’ (Power 1997). Similarly, Marilyn Strathern has recently described this newly emerging feature of global institutional practice as an ‘audit culture’, in which ideas of

‘accountability’ generate a ‘moral consensus’ that defines and validates organizational aims of efficiency and good practice (Strathern 2000: 1-2).<sup>128</sup>

The frustrations experienced by nurses and doctors at Bethesda are, to a significant extent, manifestations of this emerging global institutional culture which took root in South Africa primarily following the end of apartheid in 1994. In Chapter 2 I described the emergence of primary health care as a global paradigm, and showed that despite the apartheid government’s pitifully inadequate funding of the bantustans, the mission doctors working under the KwaZulu government between 1982 and 1994 were able to advance primary health care, providing the basis for the later extended infrastructure. The subsequent disintegration of the bantustans and the integration of health services into a single infrastructure was felt by doctors as a kind of intrusion. For them, the standardisation of procedures and the arrival of a new management system in which many more decisions would be determined by a distantly-located department of health meant that the creativity and independence that they had felt under the KwaZulu government, and the leverage they’d had over government policy, was quickly eradicated. For health workers at Bethesda, this marked a deep ambivalence towards the transitional moment. Such ambivalence, as Herzfeld puts it, is born of a ‘confusion of expressive form with practical meaning’ (1992: 6). In other words, while bureaucracy is ‘a necessity for the securing of practical freedoms, it also threatened to become a rigid “iron cage”’ (ibid: 6-7). This irony emerged in the previous chapter, where the notion of ‘rights’ was felt as a potential threat, eroding the existing workplace order and signifying the removal of control and decision-making power from individuals.

The change of government in 1994, therefore, initiated a period of major transition in South Africa’s health care infrastructure. Yet bureaucratisation of government services was a process that had begun many years earlier. During the 1950s and 60s, the apartheid government brought about a transformation both ideologically and in terms of the administrative infrastructure. After the National Party victory in 1948, for example, policy governing the rural reserves was rapidly centralised: a departure from the piecemeal and idiosyncratic governance that had characterised the earlier ‘segregationist’ years (Evans 1997: 233). This marked a period of state-led repression only possible as a result of the rapid tightening and sophistication of its bureaucratic

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<sup>128</sup> Strathern defines culture here as ‘the concomitant emergence, and dominance, of what are deemed acceptable forms’ (2000: 2).



machinery (cf. Breckenridge 2005). Apartheid therefore gave rise to what Belinda Bozzoli has called ‘racial modernism’, replacing the ‘welfare paternalism’ that preceded it (Bozzoli 2004: 50-1). By the 1980s, however, its administrative efficiency had disintegrated under the pressure of mass political opposition and economic crisis (Evans 1997: 303).

Therefore, in suggesting that the material presented in this chapter is a result of recent bureaucratic restructuring is not to say that bureaucratisation is an exclusively post-apartheid process: on the contrary, South Africans have experienced many years of systematic, lean and iron-fisted bureaucratic machinery. Rather, it is the *style* of bureaucracy that has shifted since 1994, from one of highly interventionist, state administration to one modelled upon the international principles and values of private sector management. In this chapter, I focus on the idea of ‘accountability’, as a key feature of this ideological framework, and how this is being interpreted in a post-apartheid health care context.

The post-apartheid expansion and integration of health services has enabled considerable improvements in health care delivery over the last fifteen years, particularly in previously neglected rural areas such as the one served by Bethesda Hospital. But it has had other, perhaps less intended, outcomes as well. In the introduction to this thesis I outlined some of the key issues and problems facing the health care system in South Africa. In the following section, I build on this by summarising some of the more specific concerns facing health service management at the hospital level, before moving to a discussion of the informal ‘culture’ of accountability that is constructed in the workplace from day to day.

### **Managerialism and staff shortage in the post-apartheid setting**

Several specific features of the South African context are relevant to Bethesda Hospital. Firstly, Von Holdt & Maserumule (2005) suggest that public hospitals in South Africa suffer from dysfunctional management, partly due to their structure and partly to their lack of capacity. Structurally, many hospitals – including Bethesda – are managed according to a ‘silo system’ whereby managerial authority corresponds to occupational categories rather than to work areas. Hence nurses are managed along a hierarchical

structure of nursing, doctors along a parallel yet separate line of clinical management, and so on (see Appendix B). Thus no single manager is accountable for a specific operational area. The authors suggest that this generates disempowerment at ‘virtually every level of supervisor and management’ (2005: 442), fragmenting the work process and discouraging communication between different categories of worker. Lack of managerial capacity means that management are often ‘fire fighting’ rather than generating more long term strategies, such as staff career development plans (Von Holdt & Murphy 2007). McLennan argues that managerial inefficiency is due to the fact that complex policies and administrative structures have simply been transposed upon existing delivery systems (McLennan 2007b). Thus although hospital management, in general, lacks the necessary resources to implement an equally complex delivery system, an extremely strong emphasis is placed on the managerial aspect of health care, producing an excessive focus on paperwork and regulations, and generating ‘an administrative, hierarchical and authoritarian managerial culture’ (Von Holdt & Maserumule 2005: 443). The silo system of management exaggerates the hierarchical relationship between different professional levels, reinforcing an already deeply stratified labour system.

Secondly, following the fiscal restraints adopted by the government in 1996, smaller expenditure has led to severe staff shortages (Von Holdt & Maserumule 2005; McIntyre *et al.* 2006). At the time of research, the hospital suffered a 34 per cent vacancy rate amongst the nursing staff.<sup>129</sup> This has a serious impact on staff workload and on the quality of service delivery provided. Staff shortage is widely reported to impact negatively on motivation and working environment amongst nurses in South African hospitals (e.g. Von Holdt & Maserumule 2005; Jewkes *et al.* 1998; Penn Kekana *et al.* 2004).

Thirdly, Von Holdt & Maserumule identify a widespread lack of discipline that they link to the political transition to participatory democracy, involving the demise of ‘the old apartheid disciplinary regime in the face of worker resistance and democratic expectations, and a failure on the part of the institution to establish a new disciplinary regime’ (2005: 450). This problem is particularly severe at Baragwanath Hospital in Soweto, in which laziness, stealing, and a complete absence of disciplinary procedure has generated a profound level of ‘demoralisation and cynicism among honest and hard-

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<sup>129</sup> These figures were obtained from the ‘Bethesda Hospital Strategy Plan 2006 – 2008/9’.

working staff' (ibid: 447). Almost all members of staff at Baragwanath, the authors report, have 'nostalgia for the time when Baragwanath functioned effectively as a hospital, a time when supervisors knew how to supervise and discipline was discipline' (ibid: 439). At the epicentre of worker unrest and strike action in the early 1990s – resulting in deep and persistent tensions between workers – Baragwanath is clearly an extreme example (see also Horwitz 2006). Yet similar types of issues arise, albeit to a lesser extent, at Bethesda as well. Indeed, as the previous chapter demonstrated, nurses at Bethesda feel similarly nostalgic for a period in the past when hierarchical discipline was unambiguously endorsed and respected. Instead, older nurses feel that a new rights-based discourse has undermined their claim, as seniors within a highly stratified profession, to superior status and unquestioned authority. At the same time, nurses frequently respond to the huge workload generated by ongoing staff shortages, as Von Holdt & Maserumule demonstrate at Baragwanath, with high rates of absenteeism, poor punctuality, and low work levels.

Despite this, as I will show in this chapter, nurses at Bethesda demonstrate an intense anxiety about 'accountability' in the current work context despite the fact that the formal procedures of accountability are undermined by poor managerial structure and low capacity (McLennan 2007; Wenzel 2007). Accountability works not only through formal structures but also at an informal level, generating an 'audit culture' in the workplace that has a profound effect upon the feelings of nurses about their work, and upon the types of behaviour that they engage in.<sup>130</sup> This chapter will explore the idea of 'accountability' at Bethesda as a rhetorical device within a wider 'audit culture' that generates and influences social processes in the workplace, with staff motivated to behave in particular ways by their fear of the consequences of making a mistake. With Strathern I argue that channels of accountability encourage a 'moral consensus' in which institutional aims and agendas are privileged over individual ones. Furthermore, I will argue that accountability does not necessarily yield change or productivity at the level of practical implementation. Instead, it yields a locally mediated and meaningful version of accountability which encourages particular types of responses, such as the prioritising of paperwork over clinical tasks.

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<sup>130</sup> Shamsul Haque distinguishes between 'formal' and 'informal' accountability within an institution, formal accountability referring to official rules, regulations, codes of conduct etc. and informal accountability referring to organisational culture, peer pressure and other unofficial forms of knowledge that are generated by workers within the shared, day-to-day interactions of the workplace (2000: 606).

The next section discusses some daily events of the TB ward, showing how hierarchical relationships are constructed in the process of ongoing interactions. It is through such interactions that one basic form of accountability comes to be understood and enacted.

### **Accountability and hierarchy in the workplace**

The TB ward is one of the busiest in the hospital owing to the fact that tuberculosis is one of the most pervasive and widespread diseases in the district of Umkhanyakude. With a prevalence rate of 20 per cent of the catchment population and a cure rate of 42 per cent (in 2006), it is the most severe epidemiological threat in the region alongside HIV.<sup>131</sup> The rapid increase of HIV/Aids prevalence in the area has caused a resurgence of TB including new drug-resistant strains, with the large majority of TB patients also HIV positive. The main male TB ward contains 14 beds, but several other rooms have been converted to include more TB patients. The room is bright during the day, with large windows looking out onto the small paved courtyard outside. Two large ceiling fans spin constantly and a television provides a continual hum of background noise, although no-one ever seems to be watching it. The walls are a pale yellow colour, and decorated with various posters produced by the Department of Health, covering topics such as sanitation, breast feeding, and patient rights. At the end of each bed is a tall, metal stand upon which rests a large red folder, the patient file, containing medical information of the corresponding patient.

Nurses are allocated jobs on the basis of their level of training, and are therefore separated into specific, hierarchical categories. Nursing assistants (one year of training) have limited responsibility and carry out basic tasks, including feeding and washing the patient, recording vital signs and other non-invasive tasks. Staff/enrolled nurses (two years' training) have additional tasks such as administering medicine and taking blood. Registered/professional nurses (four years' training) observe, assess and record symptoms and progress of the patient, take direct instruction from doctors, and deal with more complicated cases, in addition to performing some administrative duties. Finally, senior and chief professional nurses do the above, in addition to managerial tasks and human resource management on individual wards. Nursing care is generally

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<sup>131</sup> See 'Bethesda Hospital Strategy Plan 2006 – 2008/9'.

structured such that nurses are assigned individual tasks (such as administering medicine or washing patients) that are applied to everyone on the ward, rather than nurses being assigned the total care of individual patients. Whilst this task-oriented method is supposed to generate greater efficiency and speed, many complain that nurses do not have enough knowledge about individual patients as a result. As the chapter will explore later, there is often not enough time to fill out the necessary paperwork on patients to compensate for this problem, and paperwork is then filled out arbitrarily because of work overload.

From 9 until about 11 each morning is the period of most activity, as the doctor carries out a 'ward round' in which he assesses each patient in turn, checking progress, prescribing and administering medicine, and communicating information and instruction to the nurse who accompanies him. Although the ward sister (professional nurse) is supposed to carry out this task, she is often preoccupied in the female ward or elsewhere, particularly given the shortage of staff. The job of accompanying the doctor is undertaken, instead, by a staff nurse. The accompanying nurse responds to questions from the doctor, giving him information about the condition of the patient, and acting as a translator for the doctor who can speak only a few words of Zulu.

Such use of language brings into focus the relationships of authority between different staff members, and provides a context in which these are both reinforced and also negotiated. On one occasion during a ward round, the doctor was examining a patient who had a drain from his chest attached to a bottle below his bed.<sup>132</sup> The doctor said to the nurse, 'When was this bottle last changed?'

'I don't know', she replied, and asked the patient the same question in Zulu. He mumbled a reply. The doctor interjected: 'You shouldn't have to ask the patient. The nurses should know. Has it been like that all weekend? They haven't changed the bottle since Friday?'

She replied: 'Since on Friday. I don't know what I must do then?' The doctor by now appeared irritated, speaking in a loud and urgent tone: 'Do you understand how infectious, the way an infection' – his statement was interrupted by ringing on his mobile phone. He answered and had a short phone conversation. He put the phone back into his pocket, pausing whilst returning his attention to the situation, and continued: 'The

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<sup>132</sup> A drain is inserted into the chest in order to remove fluid that has built up in the pleura (the membrane surrounding the lungs), a condition known as a pleural effusion.

bacteria will grow inside this bottle and go up the pipe and into the chest'. He was holding the bottle to illustrate. 'It becomes an infection risk to other patients as well... Can we get someone to empty this *now* please', he said firmly, and added: 'And we need to chart it so I know how much fluid they're losing.'

Before leaving the ward to follow the doctor's instruction, she said 'I can't be here from Monday to Sunday'. This statement was spoken at first defensively, but she began to laugh as though having made a joke. The doctor responded, laughing and with a lighter tone: 'I know, we can't be!' She smiled and left, returning about three minutes later. 'Is someone looking at that now?' he asked her.

'Yes, I've called someone', she replied. A few minutes later a junior staff nurse arrived to change the bottle.

In this instance, the doctor is annoyed both by the nurse's inability to answer his question, and by the apparent negligence on the part of the nursing staff for not having changed the patient's bottle. The nurse's statement about being unable to work 'from Monday to Sunday' was a way of implicitly absolving herself of responsibility for this mistake. The doctor, noticing her embarrassment, complied with her claim by associating himself with her through the inclusive use of the pronoun 'we' – presumably referring to their joint status as senior clinical staff – undermining his own authority over her, and relieving with laughter the tension created by his previous reproach. The use of humour on the ward often has the effect of temporarily redressing the power imbalance between individuals that is expressed in, and consolidated by, other forms of linguistic exchange. This is a typical example of how hierarchical relationships are drawn upon and manipulated in the subtle and ongoing process of deciphering culpability on the ward. Whilst on the one hand, the nurse is quite clearly answerable to the doctor, she also subtly diverts blame from herself, by suggesting that, had she been there, the job would have been completed. This is an example of how nurses negotiate face-to-face accountability with the doctor during ward rounds.

One Thursday morning, the doctor was discussing a patient's condition with the staff nurse accompanying him during a ward round. 'Is his ultrasound ready yet?' he asked her, 'because I think I ordered it at the beginning of the week'. They looked at each other momentarily, before he walked away out of the room without waiting for an answer. As he left the nurse whispered to nobody in particular, although loud enough for myself and nearby patients to overhear: '*haayi, izolo*' ('no, yesterday'). A few minutes later, the

doctor returned, asking her again, 'did he go?' [for the ultrasound]. The nurse paused, and then said to him, 'you ordered it yesterday'.

'I ordered it' - he paused mid-sentence, picking up the patient's folder, and beginning to flick through in search of the correct date on which he had ordered the ultrasound. He took a few moments, unable to find the page, and the nurse began to doubt her own assertion, completing the beginning of his statement with a question: '... the other day?'

Still shuffling through the pages, he said to her, 'because he was supposed to have gone yesterday'. Finally finding the relevant page, he pointed his finger to the writing saying 'I ordered it on the 9<sup>th</sup> - the day before yesterday. Did he go yesterday?'

'I'm not sure, let me ask someone', she said, rushing off and out of the room.

'Okay', the doctor called after her, with a tone of restrained irritation.

The disagreement was brought to an end, therefore, following the doctor's consulting of the patient file which provided written proof of the day on which the doctor ordered the ultrasound. The file revealed that the claims of both had been exaggerated to support their respective interests. Yet it was used as evidence by the doctor, in the end, to lay blame on the nurse for not having carried out certain actions, an example of how patient files are involved in an ongoing process of audit on the wards. In this sense, the file performs a social function: as in the case of written legal documentation, it contains language that interjects in the social process of dispute, imposing finality upon it. Another good example of this is Marilyn Strathern's description of court proceedings in which ambiguous and conflicting claims to paternity are overruled by a conclusive, legal decision (Strathern 1996). By inscribing past conversations and actions in textual form, patient files act as an ongoing social mechanism of accountability. But these nonetheless remain contested at times, as I illustrate shortly.

On another occasion, I was sitting with a nurse while she was reading patient files, and was helping her to enter data into the computer while she obtained information from them. As she worked through the files, she commented on inconsistencies that she discovered, or places where information had been omitted. In one file, the doctor had failed to sign a particular procedure that had been recorded. 'That's really irresponsible', she commented to me. A few moments later, she found another file of a child who had been initiated onto Anti-Retroviral Treatment even though she had a CD4

count of 31 per cent.<sup>133</sup> Immediately, she looked at the signature next to this writing and declared the name of the doctor responsible for the error. ‘Why has he done this?’ I asked her. ‘I don’t know,’ she said with an expression of bewilderment. ‘The doctors don’t know what they’re doing sometimes. They are getting things wrong’.

On this occasion, it is the nurse who can legitimately hold the doctor to account on the basis of a recorded error. She is also able to assert her superior knowledge as a specialist nurse, making a general statement about doctors who ‘don’t know what they’re doing sometimes’. Yet, as will soon become apparent, paperwork does not always reflect accurately the activities of the ward, nor does the increasing emphasis on paperwork always generate action as in the previous example of the nurses’ failure to change the bottle, but at times offers a way for workers to *evade* active responsibilities on the wards.

The dialogue between the nurse and the doctor in the two examples from the TB ward also reveals aspects of their imbalanced relationship. It is clear that the nurse is ultimately accountable to the doctor, and her deferential behaviour expresses this subordinate status. In the second example, her whispered comment in Zulu, however, exemplifies a common form of communication between nurses which excludes the doctor, thus enabling a subversive counter-dialogue that consolidates the relationship between nurses in contrast to the invariably English-speaking doctors. In this instance, the nurse was not addressing anyone in particular, but nevertheless disputed the doctor’s claim verbally with this subversive comment in Zulu. Hierarchical categories in the daily work context are far from fixed, as these different examples show. Language is an important unifying feature between nurses, expressing solidarity vis-à-vis the doctor. Yet in the previous example, differences between nurses are implicitly exaggerated as the senior nurse and the doctor associate with one another by highlighting their shared status as senior clinical staff. As in the previous chapter, where nurses were eager to claim professional integrity in the face of severe staff shortage and high workload, here too hierarchy and accountability are closely intertwined and manipulated according to the particular context.

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<sup>133</sup> The CD4 test is a white blood cell count that determines the strength of the immune system in HIV positive patients. In most cases, the CD4 count will continue to decline at variable rates without the interception of treatment, making patients increasingly vulnerable to infection. For children, the CD4 count is measured as a percentage. In South Africa, Anti-Retroviral Treatment is only initiated when the CD4 count drops below 20 per cent.



Scenarios such as the ones I've described, in which basic tasks remain uncompleted, were commonplace. Explanations continually ranged from complaints about staff shortage and work overload to a broad sphere of accusations and blaming discourses, as exemplified in the previous chapter. The examples just given describe the frustrations that doctors feel about nurses purportedly not carrying out basic tasks, whilst nurses blame their juniors, their seniors, or management. Doctors frequently describe nurses in general terms as 'lazy' and 'uncaring', claiming that patients regularly fail to receive basic nursing care. For example, the doctor referred to in these examples reported that often patients do not receive their medicine on time or at all. Patients defecate or vomit and the mess is not immediately cleaned up. He tells me he has seen patients fall from the bed, and has had to shout at a nurse to pick the patient up. On one occasion he asked me rhetorically, 'why do you think that most patients die during the night?' Statistics show, he explained, that most patients die between about 4 and 5am. He went on to suggest that night duty nurses fail to carry out their duties because 'no-one is watching them.' Patients therefore receive no care during the night. At 11 o'clock in the evening, he continued, the nurses are 'all sitting with blankets by the heater, sleeping'. Another doctor told me on one occasion how a patient had died that day from pneumonia. She had tried to resuscitate the patient but, since none of the correct drugs were available, nurses – reluctantly - made sporadic and piecemeal trips to the dispensary and to other wards to get them. She complained that the nurses had been 'very slow'. Sounding annoyed, she said, 'I said to them: "Are we just going to stand here and watch this patient die?"' And then they'd finally scuttle off. There's no sense of *urgency* amongst the nurses'.

Yet nurses feel unfairly blamed for problems on the wards. 'Doctors also lack motivation at times,' one told me. 'They may be complaining that this is the fault of the nurses, but they are also like that. They are in the habit of dodging'. He explained that doctors 'disappear' and no-one knows where they are. They even turn their phones off so they cannot be contacted. Sometimes when the doctor is not available this nurse is forced to see the patients himself, doing whatever he is able to do but leaving aside tasks that require a doctor. He emphasised again that whilst the doctors complain about the nurses, they themselves often appear to evade their own responsibilities. Others explained the problem in terms of staff shortage, saying that failure to complete tasks was not only because of nurses lacking motivation, but also because there simply were not enough of them to do the work. 'The doctors complain for example that medicine

has not been given to patients’, one staff nurse said, ‘but if you have 15 patients to clean between two nurses, you will not have time to clean all those patients. So when the doctor arrives, of course, the medicine won’t have been given.’

Finally, animosity is felt and expressed by most clinical staff – doctors, nurses and other frontline health care providers – towards the managerial section of the hospital. This is often to do with a discrepancy between clinical and managerial priorities. Doctors are concerned, first and foremost, with immediate care of individual patients, whilst managers are compelled to consider longer term issues and the wider structural and resource constraints that put the institution under pressure. One morning, the doctor was dealing with a patient in TB ward. ‘Look at this guy,’ he said, smiling at the patient and walking towards the bed. ‘He’s doing so well. I’m so pleased with his progress!’ He turned to look at the sister, asking ‘Can he walk?’ The sister said nothing, but looked at him with an expression of uncertainty. ‘Has he been walking when I’m not here?’ the doctor persisted, ‘or just lying down?’

‘He has not been walking’, the sister tentatively declared.

‘Well, he’s got to start walking more,’ the doctor retorted. ‘It’s the only way he’s going to get better. Tell him that the more he walks, the sooner he’ll be able to go home.’ The doctor passed the metal frame to the patient, encouraging him to stand up and walk, and congratulated him enthusiastically as he did so, commenting repeatedly on how well he was improving. ‘I don’t know whether to send him home now’, he paused, looking at the patient indecisively as he struggled to push himself up and onto the frame. ‘Because if I do, he might stop walking, but he’s doing so well now! I think we’ll keep him here a bit longer.’ He paused again whilst the nurse helped the patient to walk a few steps. ‘The matron’s going to kill me, but a couple more days. He’s doing so well’.

These comments reveal an ongoing tension between the doctor, concerned for the welfare of this individual patient, and the matron, who is responsible for the running of the ward and is under pressure to reduce the hospital’s statistics for its patients’ average length of stay.<sup>134</sup> Such tensions inevitably arise in the context of resource shortages. Furthermore, the doctor’s expression of concern about going against the wishes of the matron is an indication of another type of accountability at work. Whilst the examples so far demonstrate how workers hold each other to account in the ongoing interactions

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<sup>134</sup> The current average length of stay (ALOS) for hospitals belonging to Umkhayakude District Municipality is considerably higher than the national average, which means managers face additional pressure to reduce it (see Appendix A).

between themselves and patients, the fear expressed by the doctor, in this instance, demonstrates his accountability to a senior managerial representative who is largely *absent* from the ward context. I explained, in the previous section, that a new form of managerialism had come to dominate health care provision, such that channels of accountability existed less between frontline workers themselves than between two separate spheres of clinical and managerial practice. This shift has generated a different type of fear amongst workers that motivates their behaviour in particular ways. In the next section, I turn to a discussion of the centrality of paperwork as a major feature of the wider bureaucratisation of health services in South Africa, and as the central form by which audit is ensured in the contemporary context, particularly given the absence of management from the daily practices of the wards.

### **The patient file as a technology of audit**

Studies of bureaucracy recognise paperwork, and more specifically the file, as one of its central mechanisms (Hull 2003: 291). In nursing, the documenting of paperwork has become increasingly important, particularly following the introduction of standardised models such as the ‘Nursing Process’, which was introduced in the United States in the 1960s and has since been implemented in various adapted forms throughout the world. Briefly, its implementers describe the ‘Nursing Process’ as a systematic, scientific framework to enable the provision, as Uys describes it, of ‘individualised, total patient care’ (Uys 2005: 126). It has enabled, therefore, both the standardisation of care-giving and a more systematic method for auditing the work of nurses. Because of these qualities, it has been met with widespread approval across the nursing sector. Yet others suggest that its implementation in South Africa has been largely disappointing, generating additional and unnecessary paperwork in a context in which staff and resource shortages are often critical (ibid: 130-132). In this section, I look at some of the ways in which paperwork is deployed by staff as a means both of conforming to, and resisting, the constraints imposed by such channels of audit and accountability.

From the perspective of many clinical staff at Bethesda, the completion of administrative procedures has taken priority over clinical ones. As one senior nurse working on the TB ward put it:

You write until you are tired. If you didn't write, it seems as if you didn't take care of the patient. Even if you have bathed, fed and treated the patient, if you have not written, it is as if you have not done it... And if you leave the patient, and do the writing, they say you are very excellent... Nurses write, but they don't finish the job.

This statement alludes to the frustration felt by many nurses that their work in the wards is unappreciated by management. The comment also expresses the feeling of intense pressure frequently experienced by nurses as a result partly of the additional and time consuming burden of administrative duties – especially in the context of severe staff shortage – and refers to the practice amongst nurses of filling in patient documentation as a substitute for carrying out the actual task. Given that patient files constitute the main means of documenting and accessing information about the work that has been carried out, and therefore of determining the productivity and success of health care delivery on the wards, this nurse's comment suggests that these written representations of clinical care that project such images of 'success', are constructed independently of the practical activities taking place on the wards. The successful completion of documentation has become prioritised for many workers precisely because of the potential that it has for identifying the culpability of individuals in the context of a broader culture of institutional accountability.

The practice of documenting false information in patient files in order for nurses to give the impression that they have completed the task was referred to frequently in conversations with nurses as a regular occurrence and widespread problem. One ward sister described it during a research interview in her office. She explained that a managerial requirement of the ward is to monitor and record the basic information on patients at half hourly intervals, but argued that this is unachievable given the extent of staff shortage currently experienced on the ward. 'If you have six patients,' she said, 'it is not possible to carry out this task for all those patients with only one nurse.' Despite this reality of ongoing resource limitations however, she regularly finds that 'the chart is nicely plotted every half hour'. She explained that it is impossible then to rely on any of the information at all, because she cannot tell what has been entered correctly, and what has been 'made up'. It renders all the information invalid: 'I don't mind if I see gaps,' she said, 'As long as you write what you did.' She went on to explain that 'later, you find a dead body. It can't be like this... What do you interpret this writing as?'

In this extreme example, the patient file can no longer be relied upon to provide information about patients' medical conditions. In this instance, the file has become meaningful only in its reified form as a physical marker of professional capability and institutional accountability: but one whose usefulness is ultimately called into question. In this example, the preoccupation with administrative procedure and nurse audit actually appears to have a detrimental affect on patient care. This contradiction of a possible causal relationship between excessive mechanisms of accountability and deteriorating standards of practical nursing is expressed most vividly in the nurse's suggestion that despite the written appearance of seamless patient care, you later 'find a dead body'. The tone of her voice changed following this comment, gaining a tone of urgency and frustration, as she raises this fundamental moral issue: that, in situations of a continuing shortage of hospital staff, nurses may be implicated in patient death:

How is it that people die without being seen? How does it happen? This person has been found dead. How can that be? Because you know when a patient is going to die...There was shortage before, but we were managing...

This is a serious moral challenge that nurses face on a daily basis, and one that exists partly because of the severe shortage of human resources, making half hourly monitoring unfeasible. Yet such concerns are accompanied by an intense fear of the potential consequences of individual culpability. Moreover, these fears come to take precedence in motivating the activities of nurses in certain contexts. For this reason, I argue that activities that attempt to offset these fears, such as the practice of making up data for patient files, are constitutive of – rather than anomalous within – the broader culture of bureaucratic accountability. They are part of bureaucratic procedure because they are essential for maintaining an image of 'success' that is independent of the day-to-day difficulties and inevitable shortcomings of actual work on the wards caused by staff and resource shortages.

This argument draws on the recent work of David Mosse (2005) in his ethnography of a rural development project in India, which investigates the complex and often mismatched relationship between policy and practice. Through a detailed description of events and perspectives of the different players involved in initiating and sustaining the project, Mosse describes the way in which the survival of such projects relies not on their implementation per se, but on the way in which they maintain successful representations of themselves. In doing so he attempts to move beyond the two opposing views of development which he identifies as 'instrumentalist' and 'critical'.

So on the one hand he rejects the idea of policy often held by its implementers as benignly informing and producing practice, yet also wishes to rebuff the notion of development as a unidirectional mechanism of control and domination of one powerful group over its vulnerable recipients that, he claims, has often been the presiding explanatory framework of anthropological accounts of development. Rather he appeals to a focus on the complexity and multiplicity of institutional practice, and the various and often conflicting interests, aims and intentions of actors involved in the policy design and implementation of development projects. In doing so he problematizes this very relationship between policy and implementation, arguing against the idea that successful projects are the result of good policy. He poses the following question: ‘What if, instead of policy producing practice, practices produce policy, in the sense that actors in development devote their energies to maintaining coherent representations regardless of events?’ (2005: 2).

Mosse demonstrates his case, developing a central claim that such projects ‘work to maintain themselves as coherent policy ideas (as systems of representations) as well as operational systems’ (2005: 17). He argues that the purpose of policy, rather than to inform practice per se, is to thereby consolidate the ‘interpretive community’ of various actors who will convey these coherent models to secure the necessary political support and funding needed for the project. In this sense, both ‘success’ and ‘failure’ are interpretations that are generated at the level of policy and report documentation, instead of deriving from practices on the ground. In the words of Latour, ‘success’ and ‘failure’ are ‘manufactured, not inherent’ (quoted in Mosse 2005: 184). Mosse demonstrates this through his example of the project in India funded by the UK Department for International Development (DFID), which in a matter of months, transformed from being one of DFID’s most successful endeavours, to one of its worst, despite the fact that during this period no aspect of the running or implementation of the project on the ground had changed. Rather, this radical shift of interpretation was brought about, he argues, by a change at the policy level, which meant that the interpretive systems in place to translate project success in terms of policy were disrupted: ‘the apparent chaos of the project was in part a product of the disruption of the wider social systems that mediated and stabilised interpretations’ (2005: 188).

The context of Mosse’s discussion differs from mine in obvious ways. It refers to an overseas development project in India, whereas Bethesda is a state-run public service

institution in South Africa. Considerable differences therefore come into play. Yet despite these contrasting settings, his discussion is relevant to an analysis of bureaucracy and accountability at Bethesda Hospital, because ‘accountability’ – like the types of policy to which Mosse refers – constitutes a normative discourse that is presumed to inform practice or implementation. Both contexts are the focus of ongoing impact assessment and audit, and are therefore under pressure to sustain successful ‘representations’ of themselves. Data from both contexts, furthermore, suggests that the unpredictability of this translation from discourse to practice implies a disjuncture between the two, undermining the idea that one necessarily brings the other into effect. In certain instances, as I have described, staff are motivated to fill in patient files out of a fear of individual accountability rather than from an intention to document accurately a patient’s condition.

In this section we have seen how paperwork is a means of documenting staff competency, and containing it within material format, giving it a permanency and objectivity it would not otherwise have. Patient files are thus an ongoing audit mechanism for assessing staff. The next section further explores this central idea, describing nurses’ perceptions of the potential danger implied by the collection and passage of information in a context in which systems of ‘accountability’ determine the moral legitimacy of the institution and its employees. In illustrating this, I hope to make explicit an implication of this section, that because paper work is often quite separate from the clinical work process, it seems almost to have taken on a life of its own, coming to be seen as an end itself.

### **The production of documentation as bureaucratic culture: the example of ‘Key Result Areas’**

The production, control and exchange of information is a central feature of the bureaucratic system at Bethesda, and takes the form of policy documents, audit reports, research findings, patient files, hospital memos and so on. One requirement of the KwaZulu-Natal Department of Health is that each member of clinical staff must produce a quarterly document of five ‘Key Result Areas’ (KRA). This strategy, introduced by Dr Nyembezi, the head of Department for the KwaZulu-Natal Department of Health, enables a system for informing management of individual work

plans and constitutes an additional means of monitoring and assessing clinical staff. Each KRA consists of an overall aim, for example, 'To decrease HIV related morbidity and mortality', and a corresponding output: 'Less HIV/Aids related deaths by 20%'. Below this, the document includes a table with five 'key activities' intended to achieve the stated output – such as 'Conduct at least two health promotion campaigns and surveys' – with corresponding columns for 'Indicators', 'Time' (expected for completion), 'Human Resources', 'Financial Resources' and 'Enabling Conditions' required for each of these activities (see Figure 6).

On the one hand this initiative can be seen as part of an ongoing effort to decentralise decision-making and to minimise the so-called 'gap' between policy and implementation, particularly in response to a proliferation of research that has explained the widespread problem of low staff morale partly as a result of a failure of management to involve front line workers in policy decisions (McIntyre & Klugman 2003). But on the other hand, it indicates an intensification of procedures for audit, providing another means for generating a sense of individual professional responsibility in the context of increasing focus on 'accountability' in health services.

On one occasion during fieldwork, one of the nurses asked me to assist her in writing her KRAs. She was extremely anxious, explaining that the deadline was in a few days, and that she didn't have the time, in addition to all her other work, to complete this document as well. I explained that I was happy to help, but that given my lack of training in nursing, and my insufficient knowledge of her specific job requirements or the particular short term needs and financial capacity of the department she was working for, I was not sure that I could be of much assistance. That I had neither the knowledge nor the experience effectively to offer suggestions was a concern which she dismissed immediately as irrelevant. She explained that what was important was that I was able to write, to synthesise points, to use a computer, to type quickly, and to express sentences and display them in a way that would be acceptable to management. That evening, after her shift had finished, we sat down at the computer to write them, together with another nurse who had also since requested my help.



**NAME:**  
**RANK:**  
**POST :**  
**PERSAL No.:**  
**Period of Assessment:** 1<sup>st</sup> April to 30<sup>th</sup> June 2007

**KRA 1**

To decrease HIV related morbidity and mortality

**OUTPUTS:** Less HIV/AIDS related deaths by 20%

KEY ACTIVITIES	PERFORMANCE STANDARD		RESOURCE REQUIREMENTS		Enabling conditions
	Indicators	TIME (completed by)	Human Resources	Financial Resources	
1. Promote VCT 100% 2. Conduct at least two health promotion campaigns and surveys 3. Provide condoms and femidoms in all facilities 4. Appoint and train staff in order to sustain decentralization of ART distribution points 5. Establish ART defaulter Tracer team	Target of 80% attending Bethesda Hospital will know their status Increased uptake of VCT & PMCTC services, target 80%  Increase of condom & femidom uptake by 20% Increase ART uptake to 3500 registered patients  Increase adherence to ART	Ongoing	PHC Manager Doctors, Nurses, Counsellors, Community  PHC Manager Dietician, Doctors, Nurses, Social Worker, Counsellors, Community	Normal HIV & AIDS Budget	Full compliment of Human Resources and other resources

**Figure 6. Key Result Area (KRA) document.**

The emotional effort and concern given over to the successful completion of this document was evident in the conversation between us as we worked. One of the nurses expressed her relief that we were managing to complete the task, telling me with a serious tone how much she had worried about doing it, that she had feared she would have been unable to think of the correct points, or to use a computer, and had lost sleep with worry about it. She thanked me repeatedly, saying 'The spirit of God chose someone to help relieve the trouble in my soul... I would have sat for hours staring at this work. The spirit of God has looked upon you'. I explained that I was happy to help her, especially as she had given up her time to help me with my work. She continued in the same manner of elated relief however, in between the completion of pieces of our work: 'I will sleep well tonight...I must pray to God because I don't know why he has chosen me... Why is God doing this? I must have been near to hell because God has sent someone to help me.' On hearing these exclamations, the other nurse interrupted: 'I heard a voice from God, sending me to you. I knew that you needed help and I came'. Use of this intense, religious language could be motivated in part by a strategic incentive, in the sense that the nurses were concerned to demonstrate their gratitude to me, and wanted to justify to me their need for my assistance. Nevertheless, the degree of emotional exertion invested in the process of creating the KRA document, and the concern with submitting it in time for the deadline, was an indication of the importance that they attributed to this particular activity, and certainly seemed to contradict the doctors' frequent comments that nurses were indifferent and unconcerned about their work.

As we worked, it became quickly apparent to me that the nurses' major preoccupation was with the correct visual layout of the document, which contrasted with their virtually indifferent attitude to its content. We used examples from previous years as templates, not only to guide the structure of our document, but also using much of the content from these earlier KRAs. We transferred some of the points into the current version where possible, because many of them were generic in their broad applicability and could be inserted directly without requiring any amendments. Others needed to be adjusted slightly so that they became relevant to the particular department we were focusing on. There were no discussions or comments amongst the nurses about the feasibility of the various initiatives that they were including, how these would be financed or by whom they would be undertaken, even though some would clearly require significant planning and additional financial and human resources for their practical implementation,

certainly beyond those currently available. The table did include columns entitled 'Human Resources' and 'Financial Resources', under the heading of 'Resource Requirement', but the same generic response was copied for each point without queries, doubts or comments being raised. As we worked I contemplated the already extremely overstretched workload of both of these nurses, and the inadequacy of the facilities and the staff shortages currently experienced by their respective departments. I asked one of the nurses if she thought she would be able to carry out all of these initiatives in the foreseeable future. 'Oh yes,' she told me, 'we will have to implement all of these'.

I recognize that the production of formatted and formulaic documents, often with the use of computers, has become ubiquitous in a broad spectrum of public life, both worldwide and in South Africa.<sup>135</sup> Here, I do not intend to address their efficacy in general terms, nor to assess the feasibility or effectiveness of various policy initiatives. Rather, I wish to draw attention to the processes and procedures surrounding the production and exchange of such documents in local settings, and the value ascribed to these activities. I argue that the production of the KRA document is an end in itself, serving three main purposes. Firstly, it is a surreptitious method of placating staff and their concerns about their lack of involvement in decision-making processes by creating an illusion that they have greater responsibility and autonomy than in fact they do. Thus it generates a false sense of control over nurses' work, creating a logic whereby the responsibility for any apparent 'failure' to fulfil such initiatives falls on individual nurses. Secondly, it is a means of auditing staff or, rather, of generating a culture and expectation of audit, even though the *implementation* of key results areas is not monitored. This was expressed clearly in the emotional labour given over the production of this document, and the nurses' fears of missing the deadline. Thirdly, it is a way to create and maintain a representation of institutional order, as Mosse argued. The above statement made by the nurse, that she intended to implement all the initiatives, is an indication of this, an example of the way in which nurses attempt to maintain the legitimacy of both themselves and the institution by claiming an effective link between policy and implementation.

Thus KRAs share with patient files this ambiguous misfit between paperwork and implementation. Yet this is more evident in the case of the 'Key Results Areas' document because its practical role at the level of implementation is largely absent. The

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<sup>135</sup> For South Africa, see Wilson 2001; James 2009, pp. 239-40.

example of patient files is more ambiguous because of their obvious and important day-to-day function in recording and transmitting vital information about patients. Mosse's analysis, therefore, is less convincingly applicable to the latter, relevant only at particular instances yet insufficient as an overall explanatory framework, a point to which I shall return later in the chapter.

The KRA document also signifies a wide range of possible outcomes beyond the instance of its production, in that it involves the exchange and passage of documents - from frontline workers, to departmental managers, to hospital management, and sometimes to representatives of the provincial Department of Health - tracing and mapping out the lines of hierarchy, and therefore the relational statuses between people. Relationships of seniority and rank are played out and constructed by the passage of such items from one person to the next. The transformation of knowledge into written form is fundamentally a social process, then, and one that carries with it certain risks (Strathern 1999; Hull 2003). As Matthew Hull points out, 'the physical perdurance of files beyond the circumstances of their creation situates them within a horizon of uncertainty' (Hull 2003: 290). This is significant in a bureaucratic context, because it helps to account for the enormous significance attributed to the consolidation and containment of ideas and strategies 'on paper', even in a context in which basic needs of patients are often not being met. This apparent incongruity can largely be explained by the fact that, in the new context of managerialism, the object of fear to whom workers are accountable - management - is largely absent from the workplace itself. As I showed with the examples of observations on the TB ward, informal accountability between nurses and doctors is still important, but less so now, given this new focus. In the final section to follow I look more specifically at the role of management from the perspective of clinical staff.

### **The separation and distancing of management**

A few weeks after helping the nurses to write their KRAs, I was sitting with one of them during her morning tea break. We were talking about the public servant strike that had taken place several months earlier. She began explaining to me the problems as she saw them that the hospital suffered, saying 'there is no transparency in this hospital'. She reminded me of the KRA documents that I had been helping her with, and said that

she recently discovered that all the documents were now missing. I was taken aback, and asked what had happened. She repeated several times and with obvious frustration that they were all missing: 'They are saying that they did not receive them. So we are having to do them again! That is what I mean that there is no transparency... We do not know where these documents went.' As she finished these words, she began to look agitated, sitting forward on the edge of her chair and looking down at her hands, and before I had the chance to inquire any further about what had happened to them, she stood up abruptly, saying that she only had ten minutes of tea break and that she must get back to the ward, and with a brief 'goodbye', rushed off down the corridor.

The disappearance of the KRA document symbolised for this nurse a failure on the part of management and highlighted a feeling of distrust in her relationship with managerial representatives, a feeling which was given moral authority through reference to the normative discourse of 'accountability', indicated here by her use of the idea of 'transparency', and the way in which she turned this idea back upon management. Yet her frustrations were rooted in a perception that management was ultimately exempt from the structures of accountability to which she felt nurses themselves were subjected.

Fears of accountability are reflected in – and exacerbated by – the image of management as distant and invisible. This 'othering' of management is evident in the example just given in which the nurse refers to management in terms of a separation between 'us' and 'them'. As I explained in Chapter 2, the clear distinction between managerial and clinical spheres emerged after the 1994 ANC takeover, prior to which the hospital Medical Superintendent also assumed the role of Hospital Manager. This later fragmentation of the two spheres has resulted in a tension whereby senior managerial staff are criticised for rarely attending the wards or observing the daily provision of medical care, and are perceived to be overly concerned with bureaucratic matters. Indeed, it is this apparent division between bureaucracy and frontline 'care' that lies at the heart of the tensions presented in this chapter. The following quote by a community service doctor expresses these sentiments well:

We [doctors] are in contact with the patients every day. You know, you see how things on paper either negatively affect patients or things that are supposed to enhance patient care actually have no effect whatsoever, you know, and that never gets to the top... because they sit in little glass offices up there. But I think sometimes it looks beautiful on paper, but [they] actually have no idea how to implement it, have no idea if it's actually going to be workable, and have absolutely no clue how it's going to affect the patients at the end of the day.

This statement expresses explicitly the concern introduced earlier in this chapter: that the projects and policies designed on paper seem often to have no discernable effects for patients. The idea of a policy being ineffective yet looking ‘beautiful on paper’ is a metaphor often evoked by doctors, and brings to mind the centrality of image, appearance or of ‘representation’ (Mosse 2005), as the underlying function of policy documentation, rather than any tangible effects that they ostensibly facilitate. In this quote, the separation of management from medical practice on the wards is offered as the main reason for their ineffective policies.

The doctor’s explicit criticism of management contrasts with the more cautious approach of many nurses, evidenced in the nervous display by the nurse as she rushed back to the ward. Unusually outspoken in her criticism of hospital management, she perhaps became sensitive to the possibility of having disclosed too much, an example of the way in which the culture of accountability serves as a check on the actions and statements of employees. The doctors’ more open critique of managerial practice is a reflection in part of doctors’ greater autonomy and flexibility, and their high status within the hospital hierarchy vis-à-vis nurses. Furthermore, most of the doctors intend to stay at Bethesda for only a short period in the knowledge that they will soon easily find work elsewhere. This also impacts on their perceived freedom to openly criticise management in a manner that nurses tend usually to avoid.

Thus doctors are able to criticise, in part, because they occupy a position of privilege. They have authority in the clinical context and, furthermore, due to the split between the medical and managerial spheres, they do not bear responsibility for the longer term planning of the institution. Thus, many of them have developed a pronounced clinical bias whereby their primary concern lies with the immediate care provided to patients. This is explained by Michael Herzfeld’s insightful claim that: ‘Rejecting the hateful formalism of bureaucracy is itself a conventional, formal act, and identifies areas of tension between official norms and more localized social values’ (Herzfeld 1992: 4). For Herzfeld, it is not that bureaucracy *fails* when it does not fulfil what it purportedly claims to do, but rather that this reflects an inevitable inconsistency between ideology and practice, both of which are constitutive of the system of bureaucracy.

Finally, to return to my conversation with the nurse, her unease was enhanced by the context of our discussion, and particularly given my role within the hospital as a

researcher. At that moment I may have represented for her a potential danger implied by the collection and passage of information in a context in which systems of ‘accountability’ determine the moral legitimacy of the institution and its employees. This raises important questions about ethnography as yet another form of document production and highlights my own positionality as a person with, like doctors, particular privileges and claims to authority.<sup>136</sup>

## **Conclusion**

Situating the discussion in the context of extensive bureaucratization of health services both internationally and, more recently, within South Africa, this chapter has attempted to describe some of the features of bureaucratic organization at Bethesda Hospital. I have described these from the perspectives of frontline workers, arguing that a ‘culture of accountability’ creates various social mechanisms by which the actions of employees are both generated and criticised. The fear of making mistakes in a context in which individuals are made to feel more and more accountable for their own activities compels people to minimize these risks for themselves, such as to ensure that paper work has been completed, even (or especially) when clinical work on wards is incomplete. Using the two examples of patient files and the Key Result Areas (KRA) report, I have illustrated that paper work is the mechanism by which the capabilities and achievements of employees are either consolidated or undermined, and that this motivates them to prioritize administrative over clinical tasks. Paper work then, becomes an end in itself, rather than necessarily enabling or facilitating the clinical care of patients. Drawing on David Mosse’s argument, I suggest then that this so-called ‘gap’ between normative models and practical implementation, rather than being an obstacle to structures of bureaucracy at the hospital, are in fact a necessary and constituent feature of them because of the need to sustain successful representations that will maintain themselves independently of the ultimately more challenging and ongoing shortcomings, contradictions and problems of day-to-day patient care. Such practical problems at the

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<sup>136</sup> The implications of this are diverse. Methodologically, to assume the role of ‘researcher’ can create obstacles. I found that junior nurses, for example, were often more reticent in expressing their opinions to me. Therefore: how is the ethnographer involved in the hierarchical power relations that exist between employees themselves? And how does this impact on data collected? Ethically, it raises the question: to whom or what is ethnography itself accountable? (cf. Riles 2006). These are questions to which I do not attempt to provide a conclusive answer. Such questions did, however, guide the process of fieldwork and assisted in developing a reflexive understanding that enabled my data to incorporate sensitively these concerns.

level of implementation are ultimately due to the severe staff and financial shortages which create an intensely demanding working environment and a degree of work overload which is born predominantly by the nursing staff.

A distinction must be made, however, between the two examples just mentioned, for whilst KRAs do appear to be arbitrary in terms of their relationship to practice, patient files have an obvious and important role, albeit at times undermined. Mosse's argument therefore, whilst revealing and relevant in certain aspects, cannot provide a comprehensive explanation. To do so would risk inadvertently adopting the same clinical bias as some of the doctors, in which immediate medical care is unproblematically centred as a moral priority, whilst bureaucracy – in spite of its indispensability – is de-centred. Yet aspects of bureaucratic structure have been criticised by many authors who argue, for example, that in a context of weak organisational capacity and insufficient resources, such a focus on autonomy, managerialism and paperwork has inhibited, rather than enhanced, efficiency and accountability in South African public institutions (Wenzel 2007). In this sense, the bureaucratic mechanisms through which accountability is ostensibly ensured imply an underlying gap between rhetoric and practice. Yet as I have suggested already this gap is integral to, rather than a distortion of, bureaucratic structure.

A culture of accountability at Bethesda motivates staff to compete with one another through blaming discourses that express a desire to avoid accusations of negligence. Often, such accusations rely on claims to professional status and group membership – as I showed in the previous chapter – and blame is thrown at particular categories of people such as 'nurses', 'students' or 'management'. Accountability practices and a focus on managerial authority therefore feed into an already extremely hierarchical workplace. What appears as a uniform culture of accountability is, in fact, a deeply stratified one. The systematising of bureaucracy has created the impression of an increasingly formal and standardised way of doing things, and is given moral weight through liberal democratic concepts such as accountability, transparency and rights. Yet this seeming stability stands in contrast with the wider sense of chaos engendered by the severity of ill-health and staff shortage in the context of rapid political and social change. Such shifts produce both moral and professional insecurity which is expressed in the fearful sentiments of staff as they respond to, and in so doing generate, the 'audit culture' by blaming one another. In the next chapter, I return to the theme of religion –



focusing on a hospital-based Born-again prayer group – to explore the ways in which nurses engage with, and try to address, these moral concerns relating to work.

## **Chapter 6**

# **Born-again Christianity at work: hierarchies of the sacred and the profane**

### **Introduction**

This chapter describes one of the several ways in which nurses at Bethesda are responding to current dilemmas in their workplace, in this case through the imagery, practice and social interaction carried out in the context of a particular kind of Christian worship, that of the Born-again prayer group at Bethesda. The association between Christianity and nursing that was initially cultivated by missionaries with the introduction of modern nursing to South Africa, and inspired by the biblical emphasis on physical healing as a form of spiritual renewal and wellbeing, has ensured that a Christian work ethic is deeply rooted within the nursing profession. Born-again Christianity is enabling the rejuvenation and refashioning of this idea in a context in which patient care within the profession seems increasingly to be lacking. Whilst only a minority of nurses attend the Born-again group, Christianity is, in one way or another, extremely significant in the lives of almost all the nurses, and the Born-again group is a clear example of how religious sentiments are expressed by nurses in a communal and organised space. Born-again Christianity – among other things – provides a commentary on the hospital's social order and the power dynamics implicit within relations between different employees. But these workplace tensions also emerge in the politics of the prayer meetings themselves. I focus on this group, rather than on other types of religious participation by nurses (of which there are many), because it takes place at the hospital and consists exclusively of hospital employees. This engenders a very particular emphasis during the session that arises in a context in which all members share the same day-to-day work space and experiences.

The previous chapters have described the historical and contemporary development of hierarchical, bureaucratic structures at Bethesda, showing in what ways these generate contradictions and disputes amongst nurses. The present chapter develops this theme further, demonstrating another way in which these structures are being challenged,

whether directly or indirectly, by nurses. The chapter therefore contributes to a broader argument of the thesis: that what was once a more taken-for-granted hierarchy is now being challenged from different angles through public debate and social discourse associated with changes afoot in the new South Africa.

Much of the literature on this subject in Africa uses the term ‘Pentecostalism’ or ‘Pentecostal-charismatic’. Whilst drawing upon this relevant literature, I use the term ‘Born-again’ in reference to the group at Bethesda because this is the self-descriptive term used by many members of the group. The term Born-again refers to a Christian who has had an intense conversion experience, which is interpreted as a kind of profound spiritual rebirth. It is often not linked to any particular denomination, as is the case with the group at Bethesda. In the next section I explain these issues in more detail, but I begin with a short description of my first encounter with the group.

### **Born-again Christianity at the workplace**

One evening, as I was walking through the hospital grounds on my way to the car park, I heard the sound of four or five voices singing loudly, piercing the still and quiet atmosphere that always descends over the hospital in the evening. Following the voices, I walked back along the little path that lies outside of the main core of buildings. Past the paediatric ward the path opens out onto a small, grassy courtyard, across which I could see the brightly lit dining hall. Three nurses were standing in the hall, facing in different directions, with their arms stretched out above their heads, palms facing outwards. They were singing fervently - and in harmony - *‘Igama lakhe lihle, Igama lakhe lihle...’* [‘His name is great, His name is great...’]. Two others sat on chairs staring upwards or with their heads resting in their hands. I hesitated outside, but as more nurses bustled into the room, and began to put out rows of white plastic chairs, I decided to join them.

A nurse who I had got to know quite well in the clinic where she worked saw me and, momentarily surprised, welcomed me with a hug and enormous grin. She was gleaming and sweating, enthusiastically drawing people into the room whilst singing. The nurses were dressed in their own, brightly coloured clothes rather than their work uniforms. About 20 nurses and one administrative secretary gathered in the room, mostly finding seats at the back of the rows. My friend addressed the group in English, pleading for everyone to move forward: ‘Don’t put yourselves down. Come to the front! Never put yourself down, because you are special in the eyes of God. Can God see you back there at the back? I don’t think God can see you back there!’ A handful of us shuffled to the front, but most stayed at the back, leaving much of the first two rows unoccupied. A further trickle of people over the next couple of minutes however mostly filled up the front rows. Altogether, we filled about a quarter of the space of the hall. The rest of the room was bare, with rows of white tables and chairs stacked up along the side. The walls and floor tiles were white, and a small kitchen area to the right of us, from which food is served over a metal counter during the day, was dark and empty.

The meeting lasted for just under an hour and consisted of singing, a sermon referred to as the 'Word of God' which was given by the nurse who had greeted me who seemed to be leading the session. Participants were then asked to voluntarily come forward to give a 'testimonial'. Testimonials usually consist of recalling an event or experience that the speaker has had, that in some way acknowledges or reveals God's presence or work in their lives. These are most often tales of good fortune, in which the speaker has unexpectedly received money or some other turn of luck, which is interpreted as a sign of God's power and positive influence.<sup>137</sup> This was followed by two or three minutes of simultaneous, individual praying that took place spontaneously and initiated by one person following a song. At the end of the meeting, we hugged or shook hands with one another on our way out.

Set up in 2006 by a Nigerian doctor, Dr Abati, then employed at Bethesda, the Born-again prayer group had only recently been established when I began attending during fieldwork. The group's meetings were held on Monday and Thursday evenings, between 7 and 8pm, and were usually attended by about 20 people, although numbers varied from five to about 50 (on one occasion when there was a visiting speaker). Members included mainly nurses of various categories from student to registered nurse, although no senior, management level nurse or matron attended the group. It consisted largely, therefore, of junior nurses. This is significant given the senior nurses' representation of younger nurses, described in Chapter 4, as overly preoccupied with financial remuneration and lacking the religious 'calling' of those trained under the mission. On the contrary, this chapter shows how a profound moral engagement with work is carried out by nurses occupying a range of categories within the profession. Of the nurses in attendance, most were female, except for two male staff nurses who occasionally attended, thus roughly reflecting the gender disparity of the nursing staff as a whole.

I attended the prayer group 18 times in total, between February and October of 2007. Leadership within the group changed over that period, which had a considerable effect on the relations and dynamics within the group over time. Dr Abati who initiated the sessions often attended with his wife and son and took a prominent role, usually giving 'the Word of God' and enthusiastically encouraging others to participate, until his departure from the hospital in March 2007. From then on, several of the nurses adopted a more central leadership role in his absence, and the group for several months usually consisted only of women. The gender dynamics revealed by this shift over time will be discussed at greater length later in the chapter. In August, two male Cameroonian doctors who had recently begun work at Bethesda began to attend. As with the previous

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<sup>137</sup> Testimonials are a common practice in Pentecostal and Born-again churches worldwide (e.g. Meyer 2001).

doctor who had set up the group, one of these Cameroonian doctors began immediately to assume an authoritative role, preferring to give 'the Word of God' on the occasions of his attendance. Later we shall see how this produced some tension between him and one of the nurses. In addition to these three doctors and the nurses, a member of the administrative staff or worker from the laboratory would occasionally attend. Two or three times a month a female hospital chaplain living in the village of Nkangala came to the group. Although there was a small contingent of five or six regulars, there was also a continual turnover of members, particularly because of the group's popularity amongst students who were often visiting for short periods from other hospitals. This meant that over the period that I attended the meetings, there was much variability in terms of membership.

The small number of members that regularly attended and played a more prominent role in the group - leading the meeting by introducing the various sections of prayers and singing, giving the 'Word of God', and taking a more active role in organising the event - comprised two registered nurses, a laboratory worker, the hospital chaplain, the original doctor who founded the group (prior to his departure), and one of the doctors who arrived later. Other members participated occasionally by giving testimonials, whilst yet others took more of a background role, preferring to join in with communal singing and praying. This chapter is based largely upon an analysis of the testimonials and the 'Word of God' given by these prominent members, given their more active and verbal contribution.

Whilst the group's most active members defined it as 'Born-again', several that attended were members of other denominations, including Anglican, Catholic, Methodist and the Zion Christian Church (ZCC). For many, then, the group was not chosen on the basis of its denomination but, in part, because of its convenient location at the hospital and, in part, because it was within the hospital community with which they were familiar. Whilst some nurses attended mission churches in the area, many chose not to because they were a fair distance by foot from the hospital and because they were often working on Sundays when services were held. So some attended the Born-again group while working and staying at the hospital, later returning to their own churches when visiting home. Several attended both the Born-again group at the hospital, and a local mission church. These signs of flexible mixing and matching indicate that the strict separation between different Christian denominations or allegiances to them is not

tenable. To assume such a distinction, argues Birgit Meyer, is problematic given that Pentecostal Charismatic Christianity in Africa has arisen not only within Pentecostal denominations (that define themselves as Born-again) but also in the prayer groups of Protestant Churches, in the Roman Catholic Church, and in the form of nondenominational groups that Christians may attend in addition to their own church (Meyer 2004a: 452). The Bethesda group is one such group. Thus there is not always a clear boundary between Pentecostal charismatic groups and other churches, and many of the latter are increasingly influenced by Born-again styles. The chaplain that attended the group at Bethesda visited the nearby Anglican Church sometimes, and told me that this church had also become Born-again. For whilst there were still 'orthodox members, older people who are strong to their traditional things', the services increasingly resembled the format and style of Born-again worship. Similarly, the prayer group at Bethesda seems to have adopted a 'pentecostalite style' (Meyer 2004b) even though its members do not all belong to Born-again denominations.

The increasing influence of 'pentecostalite style' has been notable in Africa since the 1980s when the global Born-again movement gained considerable impetus. Following a similar process in America, this charismatic renewal was accompanied by the emergence of a plethora of non-denominational institutions with a far wider, broad-based appeal than the mission and Pentecostal churches that preceded it (Maxwell 2006: 110-11). Drawing on a wide-reaching web of technological, media and cultural idioms, this new movement successfully tapped into an emergent, distinctively 'modern' set of values that stressed individualism and professional self-improvement, offering a new type of respectability to the burgeoning, post-colonial African middle-classes.

This new wave of Born-again Christianity shared much in common with earlier, Pentecostal mission churches in Africa, including styles of preaching, organisation and a shared set of songs and hymns (ibid: 111). Furthermore, as Maxwell describes in relation to the Zimbabwe Assemblies of God Africa (ZAOGA), Pentecostal missions to some extent set the groundwork for the wider success of the Born-again movement. For while the historic mission churches had established an exclusive and elite status amongst its members, and subsequently were closed to the poor urban population of Zimbabwe by the 1950s and 60s, Pentecostalism offered 'its own brand of respectability' (ibid: 81) based upon a rejection of the excesses of modernity rather than their consumption. Thus 'relative deprivation became marks of grace' (ibid: 82). In

doing so, it signalled the emergence of different types of class formation and challenged the social orthodoxy promoted by other mission denominations (ibid: 81). By encouraging a lifestyle centred around the nuclear family and a detachment from wider social obligations through an ideological emphasis on individualism, it offered a means to greater individual security (ibid: 201; cf. Meyer 2001).

Thus Pentecostalism and, later, the global Born-again movement grew successful in contexts in which social or economic deprivation of varying sorts had rendered people disillusioned and disempowered, searching for new ways in which to ignite a sense of belonging, purpose or hope. Charismatic and Born-again Christianity, centred on the idea of transformation and rebirth, and the rejection of one's past in favour of a new and radically altered way of living, provided this hope in the form of profound spiritual renewal. Maxwell has shown elsewhere, for example, that Pentecostal churches in Zimbabwe provide a protective space, offering young people an alternative to the destructive lifestyles pursued by many of their peers, of promiscuity, prostitution and crime. Pentecostalism enables them to envisage an alternative to the social and political forces that control their lives: 'They are no longer just citizens of a state that has broken its promises and increasingly resorts to surveillance and control; they have new *royal* identity as members of the Kingdom of God' (Maxwell 2005: 15).

Ruth Marshall shows more explicitly a dialectical relationship between Born-again theology and political consciousness amongst Pentecostal Christians in Nigeria, arguing that Pentecostal Christianity gives its members a language and imagery with which to articulate their distrust and condemnation of the state, sentiments that have gained intensity following the economic downfall of the 1980s and the severe unemployment, corruption and state violence that followed. This conceptual framework, she argues, centred on a dualism in which actions in the physical world are attributed either to God or to Satan - and hence generating an image of synonymy between Nigeria's elite power and the satanic realm - facilitates 'the articulation of strategies to create, exercise and legitimate new power relations and new opportunities for survival' (Marshall 1993: 215) that are based on the conceptualising of 'an alternate form of political accountability' (ibid: 234). She thus emphasises the potential of Pentecostalism for bringing about social and political reconstruction through the critiquing of the power structures and the moral reordering of society and of the state.

Others have been eager to avoid an overly instrumental interpretation. Birgit Meyer suggests that the success of the Pentecostal charismatic movement lies partly in the moral *ambiguity* surrounding its engagement with this-worldly concerns, rather than an overt rejection of ‘morally bad ideas’ (2001: 126). Evoking a dichotomy of good and evil, it draws and re-draws the boundaries between the necessities and excesses, the desires and risks of modernity, generating as much intrigue in what lies beyond the boundaries as within them: ‘The more one grows in faith, the more one is able to gain insight into this otherwise impenetrable and dangerous domain. The more one is filled with the power of God, the more one is obsessed with evil’ (ibid: 125). Such Christian discourses, therefore, enable engagement with an otherwise insecure and dangerous terrain; they ‘thrive on contradictions and dramatise them excessively’ (ibid: 128). In arguing that Pentecostalism encourages individualism and self-reliance, Meyer emphasises the ongoing process of moral self-fashioning that is central to the Born-again experience. Closely linked to this is the search for status in a context of limited economic and social resources. As Maxwell demonstrates, Born-again Christianity offers a powerful solution to this dilemma by generating a respectable status based on the moral rejection of particular financially consuming activities, and promoting a sense of individualism that heightens a feeling of moral-selfhood whilst facilitating a lifestyle of economic security.

For nurses, aware of the historical association of their profession with an elite social status yet burdened by poor remuneration and difficult working conditions, Born-again Christianity offers an appealing avenue towards reconciling these pervasive contradictions. Indeed, given this historical dilemma that has so deeply influenced nurse identity in South Africa, nurses seem ideal candidates for a Born-again faith. It became apparent in Chapter 4 that the elite status of mission education is claimed as the reserve of older nurses, emphasising and exaggerating the stratification of the profession. In some ways, Born-again Christianity offers an alternative construction of respectable status that is not shut off to those at the lower end of the nursing hierarchy. At the same time, it provides a way of negotiating the moral dilemmas which nurses face at work. The Born-again prayer group therefore reveals an interesting interplay between these often conflicting moral concerns and status aspirations that characterise the nursing profession.



The potential that Born-again Christianity offers for new forms of status acquisition, therefore, is an important part of its allure. Another possibly appealing aspect is the way in which gender, and womanhood in particular, is constituted.<sup>138</sup> Based on research in a women's Pentecostal prayer group in Zimbabwe, Rekopantswe Mate (2002) argues that Pentecostal Christianity engenders a modern work ethic amongst women, encouraging a desire to enter the workplace and to succeed professionally. Yet whilst pushing women to excel in the workplace, Mate argues, it simultaneously reinforces the patriarchal norms of the home: 'women should excel professionally and economically but remember to submit to their husbands when they get home' (ibid: 566). It seems, therefore, to generate contradictory values that are split along the perceived boundary between paid and domestic spheres: one in which the values of gender equality are encouraged and the other that reinforces an attitude of patriarchal control as 'attractive and legitimate' (ibid: 563). House keeping and motherhood, for example, are characterised as 'working for God' (ibid: 559).

In nursing, the boundary between the domestic and professional sphere has always been blurred, given the symbolic overlap between them (Gamarnikow 1978). The Christian work ethic within nursing was closely modelled on the idea of female Christian duty that defined a woman's role within the home. Such connections ensured the overwhelming dominance of women in nursing that persists today, despite an increasing minority of male nurses. Yet this boundary has also been a point of contestation, as many have struggled for the professionalization of nursing and its detachment from an association with unskilled, domestic labour. Thus nursing carries with it a particular set of gendered issues, fuelled by the synonymy between the doctor and nurse relationship and that of the husband and wife.

In the discussion that follows, I look at how testimonials and sermons provide members with an opportunity to talk about work-related issues and, in particular, how hierarchical structures of management are conceptualised and critiqued. As with the examples just discussed, this chapter considers the relationship of Born-again practice to the structures of power that people encounter in their daily lives and the ways in which these are conceptualised through a religious process of moral self-fashioning. This study is particularly well placed to carry out such an analysis because – unlike the majority of

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<sup>138</sup> The popularity of Born-again Christianity among women is widely noted. See Robbins 2004 for a summary of this discussion.

writing on Pentecostalism that is based upon research in churches – it focuses on a Born-again group that has emerged in the context of a specific workplace.

There are two central issues to be explored in this discussion. The first is the contrast between the verbalised discourses that are generated during prayer meetings and the internal, sometimes unspoken and subtle dynamics between group members. The former - constituting the surface narrative of prayer meetings - tends to emphasise a unity of purpose and of belief between all members, whilst the latter reveals deeper tensions not always consciously acknowledged by members that express some of the divisions and differences, as well as the alliances and shared interests, of the workplace. One is a verbal commentary on hospital hierarchy, whilst the other is the expression and generation of that hierarchy through both speech and practice. The tension between the two emerges from the fact that, because of its situation as a work based prayer group as opposed to the rather more detached context of a church, it is itself a very part of the social context to which its commentary speaks.

The second issue, following on from this, is to do with the content of these two idioms: it is an exploration of what each reveals about how the hospital hierarchy is imagined by its members. For whilst they appear to contradict each other, with one implying unity while the other stresses division, we shall see ultimately that both offer a means of critiquing the system of hierarchy at the hospital whilst simultaneously reinforcing it. In my analysis I also use the concepts of profane and sacred hierarchy. Profane hierarchy refers to social differentiations and rankings relevant in the workplace, whilst sacred hierarchy indicates a theological supposition concerning divine relations between God, Jesus, Satan, and people. I will argue that these two inform one another in different ways in Born-again discourse. Whilst at times they appear to represent each other, and the profane hierarchy is drawn up to act as a metaphor for the sacred hierarchy, the latter nevertheless enables a language with which to critique relations of power within the hospital.

I begin, in the next section, with a discussion of the content of testimonials and sermons (known as the ‘Word of God’) that I observed during Born-again prayer meetings. These discursive forms of speech always encourage a unity of purpose and belief amongst members and are consistently met with expressions of agreement and support by listeners, and never with disagreement. It is only in Section 3 that I begin to explore

the more complex power dynamics of the group and the conflicts and differences of status and position that are revealed in a variety of ways.

### **‘Satan has filed that sin’: Born-again discourse as social commentary**

Our work is supposed to be looking after sick people, but it has turned into being about competing. The wisdom has turned to hatred. People are dying so easily today, it’s just mad. But we must stand and know who we are.

These words, spoken by a nurse during a testimonial one evening, capture the sense of chaos that nurses experience in their daily work as a result of rising numbers of patient deaths from prolific diseases such as HIV/Aids and TB, many of which could be prevented were it not for the inadequate financial and human resources available. Such a situation, as I have described in earlier chapters, inevitably leads to a feeling amongst staff of being out of control and unable to meet the demands regularly placed upon them. Furthermore, the statement expresses well the sense of irony felt by many about the fact that, rather than pulling together under such difficult circumstances, an excessive competition between workers is felt to have taken hold. The final sentence is a call to arms, an appeal to unity in the face of this perceived crisis.

Cecilia, who spoke these words, is a professional nurse who began working at Bethesda Hospital in 2005. Her home is in Durban, four hours’ drive away, where she occasionally visits her husband for the weekend. At home, she attends a Pentecostal-charismatic church in Durban, called the Durban Christian Centre. Founded in 1979, this is the largest Church in Durban, describing itself as ‘transdenominational, non-sectarian’ and ‘non-racial’. This is a hugely successful, rapidly growing church, claiming to attract 25,000 attendees a week at its various locations around the city, including the prominent Jesus Dome.<sup>139</sup> Led by an American charismatic pastor and his wife, this church emerged as part of the wider global Born-again movement mentioned above.

Cecilia’s approach to the day-to-day challenges of work is influenced, to a significant extent, by her relationship with, and sense of duty to, God. For her, this is the major impetus to work hard, despite an ongoing feeling of being unappreciated for the work

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<sup>139</sup> See the website: [www.dcc.org.za](http://www.dcc.org.za)

that she does, receiving low wages and, she suggests, being a source of jealousy to others around her who do not want to work as hard. She described this to me as follows:

That's why I work hard here. It's not me; God is the life inside me. And God does not do half-hearted work. God's work is perfect... If I see a patient, I *have* to help them. It's just part of me now. Even if I want to just ignore the problem, I can't.

This resonates with a wider sentiment amongst many of the nurses at Bethesda, described in Chapter 4, in which the idea of religious 'calling' is drawn upon as a powerful motivation for work. For those nurses, this sense of 'calling' was premised upon a set of mission ideas with a *longue duree*. This comment suggests that religious motivations are similarly evoked for some nurses who were not trained through mission education, and that nurses of varying ages, occupational levels and educational backgrounds are involved in generating moral concern about their work through religious idioms.

Not only attitudes towards patients, but also disputes between staff, are understood through this religious lens. A story that Cecilia once told me about her previous workplace captures this well:

I used to go to college every Thursday. So the day before, on Wednesday, I would go to the matron's office to fetch some papers that she needed sending to the college. It was just a favour that I did for the matron. And because we were discussing where these papers needed to go and so on, I used to walk out of the office together with the matron, still talking. One day, one of the nurses that I worked with shouted at me, accusing me of speaking negatively about her to the matron. I later realised that it must have been because the other nurses had seen me speaking with the matron, and they were jealous that I was becoming friends with her. Soon after that, this nurse that had been rude to me fell ill and was admitted to hospital. Others were visiting her, but I didn't want to go because I didn't know how I was going to be received. After a while, one of the other nurses urged me to visit. When I got there, I was so shocked by what she [the patient] said to me. She said, "Cecilia, is that you? Sit down and take off your shoes, just rest your feet." She continued, "I want you to remove your shoes because we've put black magic onto them. We wanted you to lose the power to walk. We wanted to get rid of you. I don't want that to happen anymore, so please take off your shoes." Her sister, who was present, confirmed to me that she was telling the truth. Soon after, this young woman died.<sup>140</sup>

After telling the story, Cecilia explained to me: 'She disobeyed God by treating me in that way. You cannot treat your elders in that way. So God smote her'. As we saw differently in Chapter 4, such interpretations of events through a religious lens provides a way of staking moral claims: of taking the moral high ground in the face of workplace competition and jealousy.

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<sup>140</sup> This is not a direct quote but an approximation of what Cecilia said.

Cecilia told me this story after a particularly long day at work, in which she had argued with other staff and rebuked them for failing to put patient files away in the correct place. She'd had to stay on after everyone had gone home, in order to put them away and tidy up. She blamed the other sister who ran the department for being too concerned with gaining popularity and, as a result, for failing to discipline staff correctly. Cecilia had asked one of them to tidy up, and she had responded rudely, telling Cecilia to do it herself. In these regular disputes at work, religious idioms are deployed alongside and as part of explanations, as a way of claiming virtue in situations of conflict. Cecilia had commented to me, for example, 'I sometimes think, what have I done wrong, Lord, to be receiving this treatment? Is God punishing me? But then I think, perhaps she is like this to others too. You don't behave like this in one situation and then nicely in another.' In this statement, she switches from a sin-and-punishment centred account in which she herself was to blame, to a more essentialist account, blaming her colleague with whom she had argued.

In the remainder of this section, I look at the religious discourses that emerge – specifically in the context of the Born-again prayer group – in response to these prevalent workplace issues of competition over professional status and over one's place in the hierarchy, all experienced in the course of the stresses and strains involved in patient care.

One nurse expressed these issues well during a testimonial:

We work hard, we work very hard in our job. We work so hard sometimes, we don't know whether we're coming or going. It is Monday and we feel like it is Friday already, because we are working so hard. But remember that God has chosen us. We are missionaries, chosen by God. You need to touch your patient and your patient should be healed! You should touch your dying patient, and you should walk with them. I remember one time I had a patient, a young woman. I didn't continue with her treatment because I could see that she was dying anyway. So I just held onto her hand, and I said to her, "Do you know Jesus?" and she said, "No, I only know my ancestors". I said, "Would you like to know Jesus?", and she said, "Yes". And as she looked at me, I could see her expression, because she couldn't talk anymore, but her face was saying, "Thank you!" ...This is what God wants. It is not about the uniform, or the high heels that we like to wear... People, we've got a serious job. This is what God has asked of us, and we're going to answer!

This statement contains widely reported characteristics of Pentecostal-charismatic theology, such as the rejection of so-called traditional beliefs indicated here by the

mention of ancestors, and the moral condemnation of excessive consumption (of items such as high heels).<sup>141</sup> In addition, these sentiments play into a more specific commentary that relates to practices of health care and nursing in the current context. The speaker encourages a renewed focus on the needs of the patient, and speaks to the sense in which this is undermined by an emphasis on status, symbolised here by the mention of uniform. This message is conveyed through the account of the dying woman, a story which proclaims the ultimate importance of spiritual, rather than physical, healing, thus echoing the outlook of earlier missionary approaches to health and healing. Yet in doing so it also speaks to a widespread concern of the contemporary health system: with the tendency amongst nurses to prioritise their own professional gain over the care of patients.

Nurses were not the only members of the Born-again group who emphasised the need for patient care. Dr Abati also addressed the issue during a sermon, using the identity of Born-again Christianity to define the separation between those who care for patients and those who do not:

There is a tendency not to care for patients. But if you are Born-again you are not like that, because you experience a change of heart... So you are not doing something to, say, please the matron. You do it because you want to do what's right.

In this statement, unlike the previous one, the issue of intent is raised. The doctor claims that as a Born-again Christian, your behaviour should be motivated by a moral duty, rather than by a desire to 'please the matron'. This statement contains, by implication, many of the points raised in the previous chapter. It makes reference to the system of hospital hierarchy, and hints at the pressure on nurses to prioritise the demands made by more senior, managerial staff, sometimes at the expense of their own sense of what their patients require. I described why the aims and demands of management do not always correspond to the most desirable clinical practice, and how fears of excessive audit and accountability – of 'pleasing the matron' – often come to take priority over patient care. Finally, I suggested that this concern with the bureaucratic procedures of accountability was underpinned by – but also conflicted with – a profound moral challenge centred on the welfare of patients. The comments discussed so far in this chapter are attempts to

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<sup>141</sup> This conflicts with an alternative emphasis in certain Pentecostal discourses on wealth fulfilment, known as 'prosperity gospel' (Maxwell 1988; Coleman 2002; Gifford 2001). At times, during testimonials, nurses celebrated receiving money from somebody, or receiving a promise from God for more money in the future, but usually the approach of moral asceticism occupied nurses' accounts.

respond to this challenge, encouraging a renewed sense of moral purpose for nurses. This commentary is envisaged through the framework of a theology which separates Born-again Christians from everyone else, and which looks to a divine hierarchy, in contrast to the hospital hierarchy, as a source of motivation for work. Another nurse's statement demonstrates this well:

Do each job that you are doing well. Don't come in in the morning and look at your boss [try to please the boss]. Do your work to the best of your ability. Don't do it for man, but for the Lord... He is pushing you up onto a different level... We serve God's will by not conforming to this world, because people are negative. Begin to speak positively...

In this statement, as in the previous two, the profane hierarchy of the workplace is rejected and replaced with a sacred hierarchy ruled by God, bearing similarity with Ruth Marshall's observation about Pentecostal theology in Nigeria that it offers 'an alternate form of political accountability' (1993: 234). In the above quote a central moral conundrum is addressed, that whilst much resentment is felt towards the hierarchical arrangement of nurse management, nurses are nevertheless bound, by a moral duty to their patients, to conform to this hierarchy. The concept of sacred hierarchy offers a legitimate alternative to the hierarchy of 'this world' and, importantly, one in which personal promotion is possible: 'he is pushing you up onto a different level'. This comment speaks to the value that is given, by nurses in particular, to achieving high status and to moving up the ranks of the profession.

These two alternative sources of authority – sacred and profane - are once again implied in the following speech by Dr Abati, using the imagery of an opposing dualism between Jesus and Satan.

Maybe earlier today you did something wrong. Someone said something to you, and it made you so angry. You boiled up, and out of anger, you said something you shouldn't have. Afterwards, you realised that you shouldn't have done that. In that situation, you say, "Sorry God!" - because Satan has filed that sin. He doesn't miss a thing. He is filing a report. What you must do is take that report to Jesus. Hand it to Jesus, and Jesus, not Satan, will have the final say. Then you can say to Satan, "Satan, shut up! Satan, shut up!"

As he shouted these final words, he pointed his index finger outwards dramatically and repeatedly, as though Satan was standing directly in front of him. This elicited an enthusiastic response of 'Hallelujah!' and 'Oh, Jesus' from the audience of nurses.

In this example, the doctor alludes to familiar channels of hospital management procedure to demonstrate the spiritual battle between Satan and Jesus. He refers to the hospital's system of accountability in which mistakes or acts of negligence committed by nurses are documented and filed, to be dealt with by senior members of hospital management. In the previous chapter I described the importance of paperwork for containing and documenting staff activities such that it constitutes an important mechanism of staff audit and a means by which relationships of authority can be mapped out and mediated. Here an institutional culture of hierarchy and accountability, therefore, is imaginatively reconstituted and envisaged in terms of relationships with, and between, the figures of Jesus and Satan.

Notably, it is Satan, rather than Jesus, who documents sinful activities. In this sense, there is a literal demonising of typical hierarchies of power within the hospital, which are replaced in the story by the divine authority symbolised by Jesus who is given the final say. This dualism between Satan and Jesus, then, provides a conceptual framework for understanding and critiquing the hierarchical structures of hospital management to which doctors and nurses are duty bound. As Harri Englund states, with reference to Pentecostalism in Malawi: 'the belief in the omnipresence of the Devil is, when combined with the belief in one's own salvation, a source of formidable social critique' (Englund 2003: 96).

At times less symbolic and more explicit in their critique of work-related structures of power, testimonials can offer nurses an opportunity to express dissatisfaction and other feelings about work in the absence of other organised meeting environments in which to do this. One evening, when members were invited to give a testimonial, one woman eagerly stood up and initiated a song as she walked to the front of the room. She was a student nurse who had come from another hospital to study a course at Bethesda Nursing College. She began her testimonial by saying that she had wanted to say something at the prayer group last week, but that she had been too upset to speak. She went on to explain that 'something bad happened' to do with the exams the students had recently been sitting. She explained that one of the exams had been stopped midway. The Department of Health told the students that they had to interrupt because there was a crisis, although they didn't explain properly the nature of this crisis. The exam was stopped an hour before the official end time, while everyone was still writing. As she explained this, big gasps of breath from her audience indicated shock and sympathy for



the woman's story. She continued: 'It was very painful. Afterwards we were crying, it was so painful. When it was happening, I said to God, "Why is this happening?"... But I love God no matter what happens.' At this point Dr Abati interjected with an enthusiastic "Hallelujah!"

She explained that now, the students have to go away and study in order to repeat the exams. This was upsetting because they had all studied so hard. It was much more difficult now because they had to go home and work at the same time as studying, whereas it was easier to focus on study when they were resident at Bethesda. 'So we ask for your prayers in this. It has been very painful. But I love God no matter what. I love him whether or not he answers me. God has a plan for everything... Pray for us... Keep it up!' This conclusion was met with claps and elations from the group. The woman who was leading the session this evening stood up and repeated the sentiments of the previous speaker in her support: 'Yes, it was indeed a very painful thing that happened last week. But we know that the Nursing Council's word is the final word... But it is okay because God knows everything before it has happened'.

In this example, the student nurse expressed her frustration with the Department of Health for causing an interruption in the examination and also for failing to give an explanation. Her story generated empathy, expressed in gasps and shaking heads, from the attentive audience. The story therefore engendered a communal sense of outrage that the students had been treated unfairly by their employer. This anger was counteracted, however, by reference to God which provided reassurance that there was a reason for what was happening, even if the student herself did not understand it. Although there was puzzlement that God failed to provide a response to her questions, she expressed her faith in God's larger plan for her. The story again describes, and brings into stark and anomalous juxtaposition, two sources of power that act upon events, the Department of Health on the one hand, and God on the other. They are contrasted more explicitly in the statement that was made at the end of the woman's testimonial by the chair of that prayer meeting who adopted a quasi-religious language in describing the 'word' of the Nursing Council as 'the final word', but nevertheless reinstating God as the supreme power.

These examples all suggest a certain antagonism felt towards the profane hospital-based hierarchy, and respond with a discursive rejection and replacement of it with what they

perceive as a more legitimate sacred hierarchy: one that generates a sense of moral purpose in relation to work. Two contradictory processes are at work here. On the one hand, the prayer group context offers a space in which work related problems can be aired and those experiencing them can gain support from other workers. In this sense, it offers a legitimate public space in which to critique the activities of management. As I demonstrated earlier, the profane hierarchy is demonised in favour of a sacred authority headed by God. On the other hand, however, this has an effect of dampening critique, engendering an almost passive acceptance of the structures of power that dominate the workplace. An obvious example of this kind of influence of Born-again Christianity was when one nurse had been discussing her dissatisfaction with wages while we were sitting in the ward, and she said, 'But I don't complain, because I trust in God and I know that I will receive my just reward. That's how I see it'. This central contrast between social critique and passive resignation echoes a key debate in relation to Pentecostal-charismatic Christianity in Africa (Maxwell 2006; Mate 2002; Marshall 1993). It is not my purpose here, however, to determine the 'success' or otherwise of Born-again Christianity as a form of resistance or, as Geschiere puts it, 'to become imprisoned in a resistance-accommodation dichotomy' (1999: 219). On the contrary, as Meyer (2001) shows, it is the openness and indeterminacy of Born-again theology that accounts for much of its appeal. The Born-again prayer group is a space in which nurses engage with the contradictions and conflicts of work and forge moral ideas in relation to these, that are themselves flexible and subject to change.

So far we have seen how the hospital hierarchy is treated negatively in Born-again discourse. At times, however, it is referred to in support of - even to legitimise - a claim about God. Cecilia, who presented the 'Word of God' one evening, demonstrated this point well during a story in which she recalled an incident that had happened:

I was sitting on the edge of my bed. All the windows and doors were closed, even though it was hot outside, so I don't know why they were closed. I heard God's voice saying to me, "I never made liquor". I said to him, "But what about Cana?"<sup>142</sup> "But it's all just a symbol", God said to me.

She paused her storytelling and turned to John 1, verse 1 and read aloud: 'In the beginning the Word already was. The Word was in God's presence, and what God was, the Word was.' She then read verse 14: 'So the Word became flesh; he made his home among us, and we saw his glory, such glory as befits the Father's only Son, full of grace

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<sup>142</sup> This is a reference to the biblical story of the wedding in Cana in which Jesus turned water to wine (John 2: 1-11).

and truth.’ Following these readings, she began to interpret what God had said to her. ‘It’s not really about bread and wine. It’s about the body of Jesus. It’s all a symbol.’ She repeated this last statement several times and continued:

We know that Jesus didn’t actually drink wine. Back in those days, wine was only drunk by kings, so it’s saying that when you drink his blood, you are actually a princess... Don’t buy liquor because in the Bible they drink it, because this is a symbol. God told me that, *and I was speaking to the matron there and she seemed to know what I meant also...* I was at the Durban Christian Centre a while ago, and someone there put it really well. They said, ‘It’s not about bread and wine, it’s about Jesus himself. If you’re hungry, come to Jesus. If you’re thirsty, you’ll sense his blood pouring over you’.

Finally, returning to the story of her encounter with God, she said, ‘So this is what God said to me. I can’t remember the exact day or the date, but this is the conversation that we had.’

In this account Cecilia recalls an auditory religious experience in which she had a conversation with God. In the middle of the story, she mentions the matron only briefly and apparently without prior meditation, but this seemed to serve an important function in the context of the story as a whole, in providing validation for what may, to some, have appeared an unlikely account. Although only a passing comment, this was significant in demonstrating that familiar and shared sources of worldly authority are evoked in order to enable the conceptualisation – and *legitimization* - of divine power and the relationship of individuals to spiritual authority. This example is significant in that it seemed to contradict statements made more explicitly about the nursing hierarchy, as we saw in earlier examples, that rejected it in favour of a higher spiritual power. In this example, on the contrary, the hierarchy of the hospital is used to support the authority given to God in the story. On a more subtle level the system of hierarchy experienced by nurses in their daily working environment serves as a familiar structure through which a relationship to divine hierarchy can be envisaged.

This exemplifies a point made by Marshall: that members ‘inevitably incorporate many elements of the social order which they seek to overcome’ (Marshall 1993: 242). In this instance, Cecilia inadvertently reinstates the legitimacy of the matron, and takes for granted her superior status and knowledge. At other times, as I described earlier in the section, Born-again commentary attempts discursively to displace an assumption of legitimacy in relation to the differential structures of hierarchy between various levels of nursing and between management and clinical staff. This contradiction is rooted partly in the fact that the workplace hierarchy which provokes criticism and discontent is the

very same that the nurses themselves aspire to succeed in, a moral conflict that comes to the fore in Born-again discourse at Bethesda. In the next section, I turn to a closer look at the internal dynamics of the prayer group. I focus specifically on gender, because this emerged as an important differential feature between members, as well as being a topic of commentary during the ‘Word of God’. A focus on gender provides a vantage point from which to move analytically between people’s spoken discourse and the more implicit dynamics between group members.

### **‘He thinks that he is the child of God’: gender, status and conflict in Born-again practice**

God wants women of faith. Think of Miriam. She danced in front of the whole army, and praised God’s name there in front of them.<sup>143</sup> And they were amazed at her, not because she was naked, not because she was a woman, but because she was brave. God wants women to stand like that, women that will be able to stand for the truth. In our job, us nurses, there is no more truth. There is no more truth. We are supposed to check the BP every 15 minutes, but we just go and write it in the book [make it up]. God needs us to raise up the standard! Doing God’s work is like saying, “I’m going to do this in the correct way, even if the whole ward is against me”!

This statement by a nurse during the ‘Word of God’ reiterates issues described in the previous section, of work related experiences of competition between nurses and of a loss of moral conscience in nursing, to which Born-again Christianity offers a solution, providing a renewed motivation for focusing on patient care. The speaker makes reference to the practice, described at length in the previous chapter, of nurses making up false information and recording it in patient files, demonstrating further how this activity is a focus of moral concern and distrust between nurses. She uses the concept of womanhood as a hook with which to engage her audience. She identifies this feature as the shared characteristic of all members on this particular occasion, and in doing so, draws easily on the associations of nursing with womanhood. In this section, I look at the disparity between verbal commentary and practice in relation to gender, suggesting that whilst gender stereotypes are continually reinforced in speech by women, nevertheless it is a shared sense of womanhood within the space of the prayer group itself which offers a means of counteracting the typically competitive ethos of nursing at Bethesda, and in addition, of challenging the dominance of male doctors.

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<sup>143</sup> This is a reference to the Old Testament story of Miriam who danced to celebrate the Israelite crossing of the red sea (Exodus 15: 20-21).

Nurses that attend the prayer group often converge as women, and the group offers a means by which women find common ground with one another. This is most evident in the contrast between the content of sermons and testimonials when attendance is exclusively female, and when there are men present (usually doctors but occasionally a male nurse). On the frequent occasions when the group consisted only of women, gendered language – addressing each other as women, daughters, ‘princesses’ – often came to the fore, as well as a greater emphasis, during testimonials and the ‘Word of God’, on issues and experiences that are associated specifically with women. On such occasions, they seemed automatically to adopt a gendered focus, appearing to take on a resemblance to other Christian women’s groups in South Africa such as Manyanos (Gaitskell 1982). The following statement, from the ‘Word of God’ given by Nozipho, a female lab technician who took an active and regular part in the prayer group, is an example of gender being used as a central and defining theme.

God created a male and a female. Before he created female, he was satisfied. But there was a lack. The male needed a partner. So he created Eve. Eve was Adam’s assistant. But Eve did not walk in God’s will. She deceived him and sin came into our lives. When she sinned, the Lord realised that he had to do something. He gave his son, but before that, his son had to be born of woman. Mary was the willing woman who would bear God’s son...

Look at how important a woman is in front of God. We corrupted the world as females. Again he set the world free. God wants us to be the mourners. If a woman can break a home up, then again she can build it up.

God wants strong people, those who are willing to stand for the truth. But nobody is willing to stand for the truth. God wants people who will not compromise, people who will cry. Sometimes we cry over the wrong things. Sometimes we cry over our children. But we never cry to the Lord for his mercy. God wants us to cry out for the world; specifically women. Not one person in the delivery room is joyful. We are crying because it is painful: because before a blessing, there is always sadness.

For homes to be blessed, it is the duty of mothers. It is their duty to stand in the gap for people who are ill in this place. For the government to come right and to do the correct thing, it is our job to pray. Let us take our position as females.

Mary and her sister were the ones that realised that Jesus was at the tomb. Remember the story about the alabaster of beautiful smelling oil that was broken over the head of Jesus? That was also a woman! Jesus cried out and remembered that woman.

We are the ones who have failed, and only the ones in this position can be prayer warriors. Even if your home is upside down... with prayer and trusting, I am not afraid. I do not worry. When I go home, I get onto my knees and I pray. Even at work, not a moment goes by when I am not praying. Because then God will fight my battles. So, there is no time to rest. We must be praying always... We have delivered by pain, because in heaven we will be glorified.<sup>144</sup>

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<sup>144</sup> This speech was spoken in Zulu and translated aloud into English after each sentence by another member. This is therefore the exact translation.

During this statement, reference is made to many of the experiences and activities associated with womanhood; home building and domestic work, childbirth and motherhood, and nursing of the sick. These topics are introduced with a familiar interpretation of the story of Adam and Eve, in which Eve's betrayal of 'God's will' is seen as an indication of the culpability of women for human sinfulness. On this basis Nozipho determines that women must bear the moral responsibility for solving the problems that they have created through their sin ('If a woman can break a home up, then again she can build it up'), as well as for suffering and mourning for the world's ills ('God wants us to cry out for the world'). Indeed, it is suffering that defines primarily the emotional experience accompanying these female tasks and duties in Nozipho's account. However, she concludes, it is through this suffering that women shall ultimately find their reward, a message conveyed through the metaphor of the pains and rewards of childbirth. A quintessential image of female suffering, the concept of childbirth is powerful here in its rendering of pain not as futile, but as productive. Whilst her speech makes reference to several biblical images of powerful female role-models, nevertheless the insistence on women being 'the ones who have failed', and the implication of women's rightful and dutiful place being the home, seem to reinforce explicitly the patriarchal relations of domestic life to which most women are accustomed.

In Nozipho's statement, as in the example of women's Pentecostal prayer groups in Zimbabwe (Mate 2002), women are encouraged to fulfil their domestic duties as subjects of divine will despite of, and in addition to, their professional role within the workplace. Nursing is particularly conducive to this type of assertion about womanhood because of its deep-rooted connotations with domestic work and its status as a predominantly female occupation.

In this sense, discourses on gender seem to reaffirm the typical responsibilities assumed by women as God's divine will. However, as Nozipho's speech hints, there is also a strength that is gleaned from the acknowledgement of shared identity between women. The gendering of the prayer group is indicative of this, as women draw upon their shared femininity in the absence of men (and doctors), and reveals one way in which nurses find common ground in the context of an otherwise intensely competitive professional environment. On occasion, this unity is expressed in the presence of, and in contrast to, doctors. The following is an ethnographic description of one such occasion

that I observed, in which several female nurses, two other female hospital administrative workers and a male doctor were present.

One evening the group of nurses were praying simultaneously as usual, when Dr Abati walked to the front of the room to speak the 'Word of God'. He stood quietly and purposively behind the stand facing the group, waiting for the communal praying to draw to a close as his presence at the front indicated his intention to begin speaking. But the voices continued at the same pitch. After a few moments of waiting, he began to mutter his own prayers for twenty seconds. Bringing his own prayers to a close, he paused to see if the crowd would stop. Finding that they continued, he began to clap his hands together, slowly and loudly in rhythm, in a more obvious attempt to induce the praying to end. His clapping sounded distinctly over the voices. No response. He began to speak loudly so that his voice could be heard over the others: 'Thank you, heavenly Father', and in an even louder voice, he stated 'Amen', several times repeatedly. Once again, he began to clap slowly and loudly as before, but as he continued, the women's voices gradually gained volume, and the emotional intensity of many in the room began to increase until, from a quiet murmur of sound, the room had become noisy and his clapping difficult to hear. Several nurses began to sway, putting their arms in the air, and another wept next to me, crying with long, drawn out words, 'Oh, Jesus, Oh my Jesus'. The doctor adamantly continued his clapping, matching the volume of the accumulated voices with more vigorous claps yet maintaining the same controlled rhythm and speed. After several minutes, he began to address the crowd directly: 'Please bring your prayers to an end now!' By now, two or three women had stopped, and one of them standing at the front – a senior administrative employee of the hospital – turned round and glared disapprovingly at the crowd. The doctor urged her to sit down and to encourage others to do the same, making large downward motions with both hands. Finally, and after some effort, the crowd began to quieten and sit down until there was silence in the room. The doctor paused, tired, and then began his speech by saying that he had only a little time, and that there would be time to pray later.

This explicit effort by the group to drown out the sounds of the doctor demonstrated a clear tension between the nurses and the doctor and suggested a spontaneous, yet concerted, attempt to undermine the authority of the latter. This effort, taking the form of ecstatic communal praying, conveyed its message symbolically via the sound and volume itself, rather than through the meaning of the word content. A similar point is made by Matthew Engelke (2007) based on fieldwork amongst a congregation of Friday apostolics of the Friday Masowe church in Zimbabwe. He describes occasions in which women have interrupted testimonials with song in instances where images associated with womanhood are criticised or attacked. Such interventions are acceptable in this context because of the cosmological primacy given to the medium of song over the spoken word or, in particular, over text. For them, 'live and direct language' is emphasised over biblical scripture as the means through which God's presence can be known and experienced, to the extent that the bible is rejected entirely by members. The act of singing – and the sound it creates - itself engenders, and is a sign of, the presence

of the Holy Spirit. So the voice, particularly in the form of singing, takes on a 'cosmological significance' (ibid: 202) rather than simply being a medium through which meaning is conveyed. This enables women to freely draw on singing as a powerful expression of God's presence, yet these subversive acts, Engelke argues, 'empower members to shape the flow of ritual practice' (ibid: 222).

Whilst the Born-again Christians at Bethesda do refer to biblical scripture frequently, and see the bible as a vessel of divine power, nevertheless they share with the Friday apostolics an emphasis on the immediacy of the voice, and the spontaneity of the unstructured and unplanned form taken by Born-again worship, that is felt to enhance the sense of physical and spiritual proximity to God. As one nurse explained whilst discussing how Born-again Christianity differs from other more traditional denominations of mission Christianity: 'the thing with Born-again [Christianity] is that it is about voicing your belief, putting it into words'. This verbalizing of belief enables a form of individual expression that represents a departure from the tightly structured, prescriptive style typical of the mission churches, and is a freedom which is felt to enable closer proximity to God.

Therefore, the supposition of direct communication with, and presence of, God through the act of spontaneous prayer, in the example I have described, made socially possible the women's subversive act of drowning out the doctor. As with the Friday apostolics, it was the theological credibility of God's presence being expressed through spontaneous and verbalised prayer that enabled this drowning out of the doctor, and that gave authority to their performance. I described in the previous section how Born-again discourses replace profane hierarchy with a sacred hierarchy. In so doing, they discursively challenge the power structures in place at the hospital. Here, this substitution is acted out through the symbolic rejection of the doctor's authority in favour of God's. Eventually, however, we find that the doctor succeeded in bringing the noise to an end, and in assuming authority once more. It is not coincidental, I would argue, that the person he managed to co-opt, and who urged the others to be quiet, was a senior managerial representative. As the Hospital Manager's secretary, she had a more balanced relationship with the doctor in terms of status, and felt obliged to join him, telling the nurses to be quiet and sit down. In this sense, the behaviour of the nurses finally conformed to familiar structures of power, rather than challenging them. This



echoes the contradiction apparent in verbalised discourse about hospital hierarchy, as I pointed out in the previous section.

A further example demonstrates tensions between doctors and nurses that arise in the prayer group context. A few days after a prayer group meeting, Cecilia asked me, 'Did my teaching make sense the other evening?' I told her that it had, and she began to tell me about something that had preoccupied her since that evening. She reminded me that the doctor had arrived late at twenty past seven, after she had already begun talking. Afterwards, he had approached her to explain that he had come to 'give the Word'. When he discovered that she had already begun by the time he had arrived, he almost asked her to sit down, because he said that God had told *him* to come and speak. 'He thinks that he is the child of God', she added angrily. She said that God would not speak to them both, and that 'this is just arrogance'. She felt annoyed with him, but had decided to 'just let it be', rather than to confront him. She complained that he cannot arrive at twenty past seven and expect everyone to be sitting and waiting for him. Those who want to speak should be there on time at seven o'clock. She continued: 'That is what doctors are like. He has already been in trouble for being like this at work as well'. She added resentfully that he had also told her, 'You must make these people pay their tithing'<sup>145</sup>.

This example illustrates one way in which tensions apparent in the workplace come to the fore in the prayer group context. Cecilia makes reference to workplace rivalry at the end when suggesting that the doctor's arrogance is also a feature of his behaviour in the hospital, and furthermore translates this into a point about doctors in general: 'That is what doctors are like'. Thus once again, professional statuses of the work context intrude into the politics of the prayer group, and influence claims about who is better able to speak the 'Word of God' or who is the more rightful person to assume this role. In her comments, Cecilia implicitly rejects the idea that the superior knowledge and status of the doctor gives him greater entitlement to speak, in favour of a more egalitarian approach typical of Pentecostal-charismatic approaches to worship. In their dialogue, the doctor disguised his personal sense of entitlement in a claim that God had asked him to speak; it was God's choice, not his. In this instance, recourse to 'God' as the explanatory factor is a way of avoiding conflict that would otherwise arise from the

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<sup>145</sup> The issue of whether or not tithing should be introduced to the group had been a topic of recent dispute amongst members, and Cecilia had strongly disagreed that tithing should be paid at all, arguing that many people belonged to churches at home and were paying a tithing there.

explicit acknowledgement of these tensions of workplace hierarchy. In addition, reference to divine hierarchy, in this case, is used in an attempt to reinforce or to legitimise workplace hierarchy, rather than to critique it.

Whilst the previous section dealt with verbal commentaries about the workplace, this one has addressed the internal dynamics of the prayer group context, showing that although the Born-again meetings provide an opportunity discursively to challenge aspects of workplace hierarchy, power differences also arise in the more subtle interactions between individuals during the meeting itself. Where the dualistic opposition between Satan and God provides members with a conceptual tool with which to critique the prevailing social order at the hospital, the relations of status and power that are part of this social order reappear in different ways to cause dispute over the roles assumed within the group, playing into a power struggle over who preaches to whom, and the statuses attached to these roles.

An analysis of gender dynamics in the group reveals that whilst spoken discourses on gender appear to reinforce the unequal power relations between men and women at home, the unity generated amongst women within the group context enables them to contest forms of male authority that materialise as part of the politics of the meeting structure. This commonality amongst women contrasts with the usually competitive nature of the workplace. However, the gendered disparity of the group also exaggerates the doctor/nurse divide. The role of doctors in the group is therefore ambiguous. For whilst in Section 2 Dr Abati's comments were synonymous with the broader commentary about hospital management, seeming to reject – with the nurses – the assumed structure of authority, in this Section I have portrayed him as representative of those structures in conflict with the nurses. This apparent inconsistency reflects his ambivalent role within the workplace. For whilst, as a doctor, he has considerable authority and clout in the clinical sphere, and as a result has much more influence over managerial decisions as well as sitting favourably in the medical hierarchy vis-à-vis nurses, nevertheless his activities are still controlled and prescribed by management and he is therefore constrained – with nurses – by the bureaucratic system in place.

## Conclusion

In a contradictory way, Born-again discourses at Bethesda seem both to confirm and to critique existing power structures that affect nurses' daily lives. This tension has occupied recent debates about Pentecostal-charismatic Christianity in Africa. In relation to gender, for example, Mate (2002) argues that Pentecostalism serves to reinforce the patriarchal norms of domestic life, while Maxwell criticises this view, stating that 'despite the fact that female Pentecostals claim liberation through their faith, their religion is still dismissed simplistically as patriarchal' (2006: 11). This chapter has highlighted the contingencies of both view points, and has pointed to the fact that elements of both may coexist and are subject to change. Erica Bornstein demonstrates a similar dynamic in her analysis of the relationship between spirituality and development in a Christian NGO in Zimbabwe where, she suggests, 'faith was used in development as both a controlling discourse of institutional power and a discourse that offered the transformative potential for change' (2003: 65). The prayer group at Bethesda offers a powerful form of female solidarity in a professional environment characterised by symbolic and actual gendered labour division.

It is the flexibility and 'indeterminate meaning' (Geschiere 1999; cf. Meyer 2001) of Born-again theology that enables it to incorporate and negotiate contradictory beliefs, aspirations and moral concerns. The language of Born-again Christianity enables nurses to critique the profane hierarchical structure of the hospital of which they are part, and replace it with a sacred hierarchy to which they express their moral allegiance. It thus provides a medium to complain about work-based problems such as high workload and poor remuneration, whilst simultaneously endowing members with an individual status that is dependent upon, rather than in contrast with, a moral concern for patient welfare. Members repeatedly reject, for example, exterior markers of status such as nice clothes and the competition between workers that such a preoccupation with professional status engenders, and are offered a superior place within a divine hierarchy that rewards renewed concern for patient care. Perhaps because of their lower positions within the nursing hierarchy, and the various barriers that exclude them from the professionalism achieved by their superiors, the status offered by Born-again faith is particularly attractive to junior nurses. Importantly, a concern for patient welfare is intricately linked to a disdain for the current system of managerial authority. Born-again language successfully draws upon metaphors of managerial power and control and, at times,

associates these with a satanic realm. Ultimately, the moral self-fashioning that is integral to Born-again discourse emerges in response to a felt crisis in health care delivery and the consequent burden that nurses assume for the extreme severity of ill-health and high mortality amongst patients and the wider community. In this sense, as Marshall argues, ‘the new spiritual power possessed by the Born-again individual cannot be disassociated from the “practical” power to transform his/her social and economic world’ (Marshall 1993: 242).

A more subtle challenge to authority occurs within the activities of the group itself, where dynamics between doctors and nurses, and competition over the role that these individuals assume during meetings, reflects the workplace tensions between them. Many authors have argued, including Maxwell (2005), that Pentecostalism often encourages egalitarianism and provides a protected sphere in which individuals can question the social order ‘outside’ of the church. Maxwell describes the Pentecostal church in Zimbabwe as an isolated social space in which members are liberated from the social and political systems that confine and control them in normal life. By looking at a prayer group that has emerged in a specific working context, I hope to have shown that the Born-again group at Bethesda does not exist in this kind of social vacuum. On the contrary, because all of the members share in common their workplace experiences, occupy a space in the hospital’s hierarchy, and are accustomed to the bureaucratic culture that dominates this working environment, associated status differentials come into play more explicitly during these prayer meetings than they might do otherwise. For this reason, analysis of Born-again practice specifically within the workplace enables a more accurate pinpointing of the ‘dialectic’ (Meyer 2001) between Born-again discourses and this-worldly concerns.

This chapter has described a new form of religious expression amongst nurses at Bethesda that challenges claims to status based on existing workplace hierarchies and offers a new avenue for status achievement. In the final chapter I explore another distinctive, contemporary process – that of international migration – that in certain ways serves a similar purpose. By looking at the various constraints that act upon nurses as they choose particular career paths, I continue to explore the relevance of gender and, as this chapter has begun to show, how ideas of status and professional superiority are intertwined with how nurses perceive themselves as women.

# **Chapter 7**

## **International migration, ‘domestic struggles’ and aspirations for status**

### **Introduction**

The achievement of upward mobility through participation in international labour markets has become possible for nurses in the context of a ‘new’ democratic South Africa, but this contrasts sharply with the predicament of many in the post-apartheid context, for whom – as Chapter 3 described – economic vulnerability and unemployment are the prevailing norm. Such a stark contrast has tended to complicate domestic relations experienced by nurses who, as working professionals, often have significantly greater financial resources and career flexibility than their husbands. In this chapter, I continue the discussion of gender initiated in the previous chapter, looking at the ways in which women’s career strategies are affected by such local, socially and historically contingent factors. Looking at the possibilities and constraints that are created for nurses in their social relationships particularly with their husbands, I use Belinda Bozzoli’s concept of ‘domestic struggles’ (1983) in order to emphasise the multiplicity and changeability of gendered relations, instead of relying on the notion of a fixed patriarchal status quo. Nevertheless, as we shall see, despite the position of nurses as highly skilled professionals and as primary bread-winners, fixed representations of gender roles still play an important part in nurses’ commentary on migration. As with the Born-again discourses described in the previous chapter – although in very different ways – international migration brings to the fore central issues concerning status aspiration and moral debate among nurses.

### **Gender and migration in South African historiography**

Internal migration has been a salient feature of the South African landscape since the late nineteenth century, driving rapid industrialisation and effecting radical shifts in the economic systems and social practices of rural African communities, processes which

have been documented extensively by historians and anthropologists of the region (Delius 1989; 1990; Murray 1981; Coplan 1987; 1991; James 1999). The question of the role of women within these processes of migration was taken up initially by revisionist historians of the 1970s, notably by Harold Wolpe (1972; see also Vail 1989) who used the production-reproduction model to explain the gendered patterns of labour migration as men moved to the mines and other industrial centres whilst women remained in the rural base. Drawing on structural Marxism, Wolpe viewed this sexual division of labour as characteristic of, and functional to, the capitalist political economy.

Yet with the growing emphasis into the 1980s on issues of gender, race, and other identity-based concepts, the materialist assumptions of this earlier work became increasingly subject to scrutiny.<sup>146</sup> Drawing on a wider intellectual shift towards feminism, for example, Belinda Bozzoli (1983) rejected the idea that capitalist modes of production determine a specific form of gendered labour division, arguing that such processes cannot be explained without an understanding of pre-capitalist forms of patriarchy. Hence, it was because of the pre-capitalist reliance upon, and subordination of, female labour in the domestic sphere of agricultural production in African society, that men were first drawn into the industrial labour market, whilst women tended to maintain the rural base, only later to be increasingly incorporated within an urbanised workforce. She demonstrates this by contrasting it with white Afrikaner migration patterns, in which early proletarianization of women was common.<sup>147</sup>

Bozzoli's concept of 'domestic struggles' contains scope for denoting a variety of gender relations, rather than seeing patriarchy in terms of a single 'structure' which, she argues, 'tends to be both a-historical and idealist' (ibid: 148). Using the term 'domestic struggles', she emphasises the contrasting roles and needs of individuals within a household, and the relationships of power and control that characterise domestic

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<sup>146</sup> 'Race' was obviously not a new concept in South African historiography, and was explored and described extensively by revisionist historians (e.g. Johnstone 1976; Legassick 1977). Yet they tended to privilege 'class' as the dominant, structuring category. Some key texts later convincingly challenged this theoretical bias (e.g. Dubow 1995).

<sup>147</sup> Amongst white families, she suggests, 'internal domestic struggle' (for labour, property, production and so on) was such that previous to capitalism, 'Boer society had *lacked* the capacity to subordinate the labour of its women', in contrast to black society whose patriarchal relations determined that women were heavily depended upon within the domestic economy (1983: 154). As such, when the demand for urban labour emerged, Boer women, whose labour was not fully utilized at home, migrated to the city and - like black men therefore - entered the industrial proletariat at an early stage. Black women on the other hand remained in the rural base in order to maintain the domestic economy. Ironically, it is therefore argued, the internal subordination of black women in their pre-capitalist context provided protection from early proletarianization (ibid: 155), thus showing that pre-capitalist forms and degrees of female subordination affected the nature of later proletarianization differently amongst different groups.

situations; she thus moves away from the somewhat more romanticised notion of the family as a single economic unit, acting in all its members' best interests. Such an analytical bias that was a feature of earlier work, whilst generally acknowledging a patriarchal relationship between men and women, often failed to see their unequal, and even competing, access to resources within the household. The earlier approach failed also to incorporate an understanding of the *variability* of domestic situations, which demands historical explanation.

Bozzoli distinguishes between 'internal' and 'external' struggle, 'internal' referring to such dynamics between men and women within the household, and 'external' to those between the domestic sphere and the broader economic system. By comparing the actions and responses of men and women to external economic pressure and, in turn, by examining the relationship between these internal and external struggles, it is argued, the notion of 'domestic struggles' provides 'a key heuristic device to unravel the differential responses of men and women to the forces of capitalism' (ibid: 148). In the current analysis of nurses at Bethesda I draw on this concept because it enables an understanding of the existence of multiple, socially and historically contingent relations between men and women – rather than to assume a single patriarchal status quo – yet nevertheless maintains a commitment to the idea of social and economic forces influencing, enabling and restricting the life course of individuals.

With this argument Bozzoli anticipates, and to a certain extent addresses, a later criticism by Cheryll Walker (1995) of gender analysis in South Africa. In particular, Walker attends to the ways in which the concept of 'motherhood' has been addressed which, she argues, have often over-emphasised the political and discursive idea of motherhood, tying it to a patriarchal model of the family in which women are defined narrowly in terms of their subordinate relation to men. She argues: 'while particular, limited constructions of 'motherhood' have been appropriated within various patriarchal discourses, these discourses should not themselves be seen as definitive of women's actual identities and experiences' (ibid: 418). In calling for a closer attention to women's day-to-day experiences of mothering, she raises in particular the fact that motherhood in South Africa has become increasingly detached from marriage, both in practice and in public, moral discourse; women increasingly choose to have children without marrying, and the number of female-headed households is on the rise (ibid: 413).

Processes of migration have contributed significantly to these changing family patterns. Schapera commented for example, in 1937, that premarital intercourse was ‘so widely practised as to have become almost customary’ (Schapera 1937; quoted in Walker 1990: 193), and this he attributed to the destabilisation brought about by labour migration. Bozzoli’s notion of ‘domestic struggles’, with its demand for historical contextualisation; its plurality that implies the existence of multiple family structures; and its problematising of the notion of a cohesive family unit, renders it a potentially useful tool for understanding the complexities of familial dynamics in relation to a wide field of economic and social activities such as migration. These changing features brought about by labour migration, as Schapera demonstrated, have been occurring in South Africa since the earliest decades of industrialisation. The purpose of this chapter is to examine the motivations – and outcomes – of a more recent form of migration in the contemporary context of post-apartheid South Africa: one which, in contrast to earlier migrations from this region, is both international and predominantly female.

As will become clear, a particular feature of the domestic context of nurses at Bethesda is that nurses often have greater economic security than their husbands. With the hospital being the major employer in the area, and women dominating the nursing profession, a significant number of households have adopted a structure whereby women provide the only or major source of income. It is therefore against a background of pervasive male unemployment that the data presented in this chapter must be understood. This relates to a broader recurring theme in the literature on contemporary South Africa: the so-called ‘crisis of masculinity’. Focusing on the changing forms of – and challenges to – masculine identity in post-apartheid public discourse, this literature has emerged in response to a number of pervasive social factors: the widespread moral panic over the spread of HIV & Aids and its concomitant challenge to images of male sexuality (Hunter 2005), called most severely into question, for example, by increasing rates of domestic violence and rumours of child rape (Walker *et al.* 2004; Posel 2005); liberal-democratic discourses on ‘human rights’ that emphasise gender equality as a new moral norm (Sideris 2005; Scorgie 2003); and, as this chapter hopes to illuminate, contestations over men’s traditional bread-winning role in a context of severe job insecurity.



These features of the local economy complicate relationships between men and women, as men engage in persistent attempts to reinforce male control in the frequent situations where this is threatened. In the context of such challenges to masculine identity, Mark Hunter has appealed to academic writers to ‘problematise representations of static African masculinities’ (Hunter 2005: 140), by historically accounting for such representations. He shares a similar concern, therefore, with Cheryll Walker, who wishes to detach the concept of ‘motherhood’ from that of patriarchal discourse.

These concerns come at a time, however, in which gender roles continue to be drawn upon and reinforced. Nurses at Bethesda, for example, frequently deploy an explanatory trope of Zulu manhood or ‘Zulu culture’ in order to explain, justify and account for what they perceive to be predictable male behaviour. Likewise, I will show later in the chapter how nurses at Bethesda evoke a traditional and fixed image of female duty to criticise those who have migrated overseas, accusing them of abandoning their domestic responsibilities in search of material wealth.

Before moving to the central issue of international migration, I relay a short account from fieldwork in order to situate more concretely this notion of ‘domestic struggles’. Lindiwe is a staff nurse living in the nearby village of Nkangala (an area I described in Chapter 3). She lives with her husband, teenage daughter and ten year old son. At the time of fieldwork, her husband was unemployed, so her wages from the hospital were the only income entering the household. Although he helped with building work at home, she complained that he spent too much time drinking. A relative of theirs, living nearby, said to me, ‘He doesn’t have a job. He doesn’t even bother to look for one, because he knows that his wife is a nurse.’ Lindiwe regularly gave money to her husband, but complained that he often spent it on alcohol. Sometimes she hid her money to prevent him from taking it from her to buy drink. On one occasion, Lindiwe gave R500 to her husband to buy a truck of sand for the building work, but he spent R200 on drink and so they were short and were unable to buy the sand. When he was drunk, they often argued about money. On one occasion, she was doing the ironing, and he took the hot iron and hit her with it hard so that she was badly burnt. She went to the magistrate, who warned him that should he abuse his wife again, he’d face a 25 year prison sentence. Since then the situation has improved.

This is an example of women's increasing use of the legal system to counteract male aggression in cases of domestic dispute (cf. Hornberger 2008). Here, the state intervened, bringing an end to the husband's use of violence as a means of asserting control, and therefore giving Lindiwe greater leverage over her husband's behaviour. Her influence at home has greater weight given her role within the household as single breadwinner, and these factors motivate his frustrated attempts to secure her earnings for himself. This story demonstrates broader structures of influence that operate upon the domestic sphere. The story is evidence of the increasing intrusion of the state into domestic affairs. Paternalistic in its undermining of the husband's physical domination over his wife, this legal process of state decision-making shifts patriarchal relations from a domestic to a broader public arena. Relations of power, then, impact on women's lives at different levels, domestic, local and national. These levels mesh with one another to produce a particular outcome. In this instance, internal 'domestic struggles' between Lindiwe and her husband were mediated by the paternalistic power of the state, an example of what Bozzoli might refer to as 'external domestic struggle'. According to Bozzoli:

Possibly those who see themselves as guardians of the domestic sphere – and who may also be the main beneficiaries of whatever internal struggles they have engaged in – will be its chief defenders; while those in subordinate or oppressed positions in the household will respond differently to external forces, perhaps seeing their encroachment as a potential benefit to them in their struggle (Bozzoli 1983: 148).

The differing responses of Lindiwe and her husband to the mediation of the state was an expression of the contrasting ability of these individuals to gain access to available economic resources. These responses also spoke of the imbalance of power between the two which, for Lindiwe, was redressed to a certain extent by the intervention of this external force. Perhaps the inversion of the traditional conjugal structure, in which the husband is no longer the breadwinner, to some extent engenders his violent behaviour towards her, and is symptomatic of a broader perceived 'crisis of masculinity' in South Africa (cf. Moore 1994).

According to Walker and Reid, South African men 'react to change in a variety of ways, from embracing and supporting new ideas about manhood and masculinity, to violently defending the *status quo*' (Walker & Reid 2005: 2). In discussing the effects on women of 'domestic struggles' at home, I do not wish to over-generalise features of relations between men and women, or to portray men as consistently unreliable and negligent.

Rather than to homogenise the motivations, feelings and behaviours of men, my purpose is to focus on the perspectives of the nurses with whom most of my research took place.<sup>148</sup> The examples presented in this chapter serve to illustrate some of the responses of women to male assertions of control in the domestic context.

In the following section, I give a brief overview of the international migration of South African nurses, focusing on migration to the UK that has been, thus far, the largest host country of nurses from South Africa. This example demonstrates the significant influence of international labour markets and immigration policy in determining the career choices available to nurses. In the remaining sections I narrow my attention to the specific location of Bethesda Hospital and its surrounding area, examining the ways in which nurses' career strategies are simultaneously affected by – and contribute to – local political and economic processes, and domestic relationships at home.

### **The international migration of nurses**

The deepening shortage of nurses internationally has attracted increasingly urgent attention from governments, policy makers and health care providers. Following the worldwide expansion of health services since the 1960s, the employment of internationally trained nurses has been an increasingly important strategy to meet these growing demands. However, for many countries including those of sub-Saharan Africa, the out-migration of health care workers puts an additional strain on these already severely overstretched health systems. During the late 1990s, South Africa experienced a significant increase in outward migration of nurses. The number seeking verification of their qualifications in order to apply for overseas posts increased rapidly from 511 in 1995 to 2,543 in 2000 (Xaba and Phillips 2001: 2-3). More than half of these moved to the United Kingdom (Bach 2003: 5).<sup>149</sup>

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<sup>148</sup> Partly, this is because I did not carry out extensive fieldwork with the husbands of my informants, and therefore I do not have data to reflect their views. Given this limitation, I focus on the perspectives specifically of the nurses, but do not attempt to give a complete picture of situations at home.

<sup>149</sup> No reliable data exists on the numbers of nurses migrating overseas from South Africa. Estimates are based, therefore, on the numbers seeking verification of their qualifications, which gives an indication of intention to apply for posts outside of South Africa. Some research has suggested, however, that current figures in South Africa are underestimates (Stilwell *et al.* 2003). The lack of accurate figures on how many nurses are migrating overseas from various countries makes it much more difficult for monitoring and policy initiatives to be effectively enforced. More reliable information can usually be found from the statistics of registration of the receiving country.

In response to severe criticism regarding the so-called 'poaching' of nurses from abroad, the UK Department of Health in 2001 issued an ethical code of practice for international recruitment of nurses. The most important change that this entailed was the prevention of active recruitment from a 'banned list' of developing countries including South Africa. This measure failed, however, to significantly curb the number of nurses entering from these countries. This was attributed to various causes, including in particular the failure of the code to cover the private sector which has itself been a major recruiter of internationally trained nurses.<sup>150</sup> It was updated in October 2004 to outline more explicit standards. Its effect nevertheless remained limited, largely because whilst it prevented the *active* recruitment of foreign nurses by the NHS many nurses continued to apply through their own initiative.<sup>151</sup>

While limited in their ability to curb migration to any great extent, these interventions nevertheless seem to have marked the beginning of a decrease in numbers of overseas nurses moving to the UK, including those from South Africa (see Figure 7). This is arguably due more to the changing nature of the job market in the UK than to that country's government's ethical code regarding overseas recruitment. Over the last few years, increasing pressure on NHS Trusts to contain costs has led to various downsizing measures taken by Trusts including, in some cases, the reduction of staffing numbers. Suggestions that job shortage and increasing redundancy were caused by the freezing and deleting of posts in the face of severe deficits has caused increasing tensions between nurses, unions and government, which reached boiling point in April 2006 with widespread threats of strike action.<sup>152</sup> During the same period, the fear that UK-trained nurses would be unable to find employment caused the government to remove nursing

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<sup>150</sup> It also only covered NHS employees in England rather than the whole of the UK, and it enabled certain Foundation Trusts to be exempt from the code.

<sup>151</sup> In addition, whilst it attempted in a more concerted manner to encourage Foundation Trusts and the independent sector to comply, it remains the case that the code is still heavily undermined by active recruitment by private sector agencies, and the so called 'back door' recruitment, referring to the employment by the NHS of foreign nurses who had initially gained entry to the UK labour market via the private health care route.

<sup>152</sup> 'Strike threat over NHS job cuts', 24<sup>th</sup> April, 2006 *The Guardian*; 'Hewitt under fire over NHS 'boast'', 23<sup>rd</sup> April, 2006, *The Independent*; 'New figures show NHS has lost nearly 7,000 nurses in last year', 24<sup>th</sup> August, 2007, Royal College of Nursing - [http://www.rcn.org.uk/newsevents/press\\_releases/uk/article2407](http://www.rcn.org.uk/newsevents/press_releases/uk/article2407)

from the recognised list of shortage professions, and therefore to bar overseas nurses from applying for junior posts.<sup>153</sup>

**Figure 7: Number of South African nurses and total number of overseas nurses (non-EU) newly registered in the UK between 1998 and 2008**

	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
South Africa	599	1460	1086	2114	1368	1689	933	378	39	32
Total	3621	5945	8403	15064	12499	13608	10985	8673	4624	2309

Source: Nursing and Midwifery Council (NMC) [www.nmc-uk.org](http://www.nmc-uk.org)

Surprisingly, this measure came only months after widespread fears of severe and long-term nursing shortage. The inconsistency led to suggestions that current recruitment policies were focused too centrally on the short-term fluctuations of the labour market, rather than on longer-term needs. In 2005, the main nursing union, the Royal College of Nursing (RCN), predicted that by 2014 newly registered nurses will need to more than double, from the current figure of 320,000 to 660,000.<sup>154</sup> The apparent contradiction that junior nurses are not finding jobs despite the significant demand for additional nursing care is an indication that the problem is located in a shortage of specialised skills, rather than of nurses *per se*. Following criticism from the RCN that the government was making ‘scapegoats’ of international nurses by barring them from employment in the UK the Health Minister, Lord Warner, responded that international recruitment was only ever a short term solution.<sup>155</sup>

This is a good example of the way in which migration patterns are affected by broader trends in economic management and, in particular, of the central importance of fiscal prudence as NHS trusts are encouraged to compete with one another in the context of a health care industry increasingly driven by ‘market’ ideology (Pollock 2005). The reduction of international nursing recruits to the UK is more an expression of this fiscal

<sup>153</sup> ‘Hospitals barred from hiring foreign nurses’, 3<sup>rd</sup> July, 2006 *The Independent*.

<sup>154</sup> ‘NHS faces recruitment crisis as nurses retire’, 25<sup>th</sup> April, 2005 *The Independent*.

<sup>155</sup> ‘Ministers ‘sacrificing careers of foreign nurses’ to solve financial crisis in NHS’, 4<sup>th</sup> July 2006 *The Independent*.

prudence than a result of ethical policies. This is particularly evident given that senior, experienced nurses are still able to apply for posts in the UK, despite the severe shortage of these specialised skills in sending countries. This is further indicative of the reduction in numbers being a short-term trend; it is symptomatic of the ‘reserve army’ nature of internationally recruited nurses intermittently filling a human resource vacuum when needed (cf. Ehrenreich & Hochschild 2003). It is highly likely, then, that the international labour market will be an important source of nursing staff for the NHS in the next ten to 20 years, despite this recent reduction.

Retention of staff within the South African health care system is to some extent influenced by these broader global trends. As mentioned, the majority of South African nurses migrating abroad have tended to move to the UK. At least 14 nurses left Bethesda Hospital to work in England between 1998 and 2002. These 14 were, without exception, highly experienced and well qualified nurses, several with degree level qualifications, and all working in senior positions. The impact of their departure on human resource capacity at the hospital was severe, particularly in a context of existing staff and specialist skills shortage. A small number have applied since then but, most probably as a result of the British policy changes described above, were unsuccessful in their applications. All in all, fewer left for the UK after 2002. Nevertheless, migration remains for many an important career aspiration, and is discussed frequently in conversations between nurses.

This brief discussion of the UK example shows the significant effects on the life course of individual nurses – identifiable even at the very local level of Bethesda Hospital – of these broader political and economic structures, determined by government agendas and national/global shifts in the ideologies, strategies and finances of health care systems. Indeed, as Bozzoli shows in the South African context, this also constitutes the broader framework in which ‘domestic struggles’ take place. What emerges, though, is that these wider processes do not simply act upon individual lives as rigid and uncontrollable forces (cf. Burawoy 2000). Rather, nurses negotiate them along with a range of factors. The next section turns to a closer analysis of some of the locally engendered factors that influence nurses’ career strategies in diverse ways, revealing that migrant activities cannot be explained exclusively by trends in the international

demand for labour or the determining structures of global capital.<sup>156</sup> I focus particularly on the ‘domestic struggles’ of nurses that, to a significant extent, shape the choices and possibilities open to them. I begin with the experience of one nurse in particular, Bongile, who recently returned from the UK and is now working at Bethesda Hospital.

### **Migratory strategies and ‘domestic struggles’**

Bongile grew up in an area of KwaZulu-Natal about 100 kilometres south of Bethesda Hospital. She went to a hospital in Mpumalanga province to pursue her nurse training, and became an enrolled nurse in 1982. She worked there for several years, later training as a fully qualified, professional nurse in 1991. In 2001, she moved to Portsmouth in England to work for two and a half years before returning to South Africa in 2003. She worked for six months in a private hospital before moving to Bethesda. She is currently working in the mobile clinic and training in Primary Health Care at the Nursing College at Bethesda.

Bongile decided to go to England after a friend of hers went there and encouraged her to do the same, ensuring her that it was easy and extremely financially lucrative. She had a five year old daughter at home at the time, which made the decision to leave a more difficult one, but her husband strongly encouraged her to go, saying that he would take care of their daughter while she was away. While in England she spent as much time as possible working, pursuing agency work in different hospitals in addition to her full time job. Despite the often extremely long hours that this entailed, the money that she earned enabled her to build a large house in Mpumalanga, as well as to secure additional savings. Such savings, as she and many other nurses often point out, would have taken many more years to accumulate on the strength of a nursing salary in South Africa. She sent money to her daughter and husband, who was then unemployed, and to other family members regularly while she was away.

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<sup>156</sup> This position was exemplified by Meillassoux in his book *Maidens, Meal and Money* (1975), in which migration is understood as a form of exploitation whereby the movements of workers are coerced in order to satisfy the needs of the global capitalist economy. This approach was then developed throughout the 1980s and 1990s. Sassen-Koob (1987) for example argues that labour movement to rich countries reflects a flow of resources from periphery to core within the global economy. This increasing concentration of capital in ever smaller geographical centres, she argues, finds its roots in the migration of workers from rural to urban areas during the earlier period of industrialization, but has shifted to a larger scale with the entrenchment of global capitalism, as the increased demand of low paid service sector jobs has attracted more and more migrants from underdeveloped countries to industrialised ones.

Lured by the financial incentive, she wanted to stay longer. But this decision was challenged by problems that began to occur at home in South Africa. She discovered that her husband was not taking care of her daughter properly, leaving her in the house while he went out. Bongile contemplated bringing her daughter to England, but decided that she would not be able to spend enough time with her, given the long hours of her work. Concerned that this would lead to her child being 'neglected', she decided to return home. She found work immediately in a private hospital at home in Mpumalanga. But during this time her relationship with her husband deteriorated causing her to leave the house, move to KwaZulu-Natal and find employment at Bethesda Hospital, bringing her daughter with her. She explained: 'I was just hiding, I was running away.'

In several respects, Bongile's story contains familiar features of gender relations in South Africa, and demonstrates the ways in which these can affect the career choices of women. Bongile's husband's behaviour intercepted the existing course of her career to create a dilemma and to demand a choice between, as she described, 'becoming richer' and her child's happiness, values that - due to her husband's promise to care for the child - had not previously been mutually exclusive. For Bongile, the struggle between the accruing of wealth and her daughter's welfare was therefore forced into the frame by the behaviour of her husband. She rarely complained about his actions but, instead, tended to focus on the moral question that it created for her. She identified a characteristic that she associates with men generally, implying that as a group their behaviour is in some sense to be expected. As she said, somewhat elusively: 'I was just planning to call her [my daughter] to come over to England but, you know, there were those things, you know how men are.' The onus of moral choice then fell entirely, and seemingly without question, on her. Although clearly she was decided on which option was more important, the experience of sacrifice and loss is palpable in the following quote, as she shifts between the two conflicting points of view:

I thought that in order to become richer, my child is suffering. The priority, it should be my child. Then I will see how I will cope. Other people are coping. It's just that I wanted to achieve everything. But I did achieve most, because even now, with the money that I made in England, I built that whole house.

This is an example of the widespread tendency in South Africa for women to assume the burden of care for children, to which many other stories testify. In the broader context of HIV/Aids - an epidemic which has placed a major burden on the social and



economic fabric of South African society - this responsibility often extends beyond the immediate family, as a further example demonstrates.

Hlengiwe is a registered nurse who, at the time of my research, was working on night duty in the Out-Patients Department. She lived with her husband and their three adult children in the nearby town of Jozini. She had recently taken in two boys, aged six and seven, whose mother was a friend of hers and had died recently from HIV-related illnesses. Both boys were being treated for TB, having become ill whilst living with their mother who was unable to care for them adequately due to her ill-health. Their father lived nearby, but Hlengiwe described him as an alcoholic who was therefore unable to take care of his children. He had a good job working for the government in agriculture, so he gave Hlengiwe money towards their upkeep. 'That is the one thing that he does do,' Hlengiwe's grown up daughter told me. She said he is becoming increasingly ill, and believed he only manages to maintain his job because his employers pity him: 'They know about his children. That's the only reason they let him stay.'

By the time of her friend's – and the boys' mother's – funeral, Hlengiwe had already been taking care of the children for three months. She discussed with their father the issue of who would take care of the boys. Their mother's family had refused because they couldn't afford their upkeep. The father would not allow them to stay with his own mother, although he wouldn't explain the reason for this. He was not able to look after them himself, so insisted upon Hlengiwe continuing to take care of them. The problem remained unresolved.

In the broader political economic context, women's assuming of responsibility for the care of the sick, or children of the deceased, signifies a hugely disproportionate amount of risk and responsibility they take on. By relieving the government of responsibilities of health and welfare of certain individuals, women's care roles here inevitably subsidise other areas of the economy (cf. Akintola 2006). The case of Hlengiwe is a good example of this; as a nurse she is treating the sick not only at work but also at home, yet she is remunerated for her work in only one of these spheres.

We return to the case of Bongile. She was responsible, in the end, both for the financial maintenance of the household and for the care of their child. However, even though her

husband's failure to take care of their daughter forced her to return home and therefore abandon her career plans, eventually she was able to move away from her husband. In this sense, the power dynamics implied in her relationship with her husband had a somewhat contradictory effect. In the first instance, it was her husband who strongly encouraged her to go abroad, but his later behaviour represented a contradictory intervention, forcing her decision to return home. Still later, paradoxically, the feeling of independence engendered through working abroad, and the accumulation of financial capital that it had enabled, meant that she was able to undermine her husband's control by moving to Bethesda. Ultimately, then, she was able to respond to the attempts of her husband to reinforce control and was able to do this, in part, because of the advantage that she has as an employed professional vis-à-vis her unemployed husband.

Bongile's story illustrates the individual complexities involved in choosing whether or not to migrate. Her story does demonstrate the importance of financial incentive in decisions to migrate, clearly reflecting a broader structural imbalance in economic terms between two separate yet interlinked labour markets in England and South Africa. Yet it also illustrates that 'domestic struggles' at home, as well as the local economic and historical context in which nurses live, impact significantly on their choice of whether or not to move. If a globalized structure of patriarchal relations – implicitly serving the needs of global capital – compels the unidirectional movement of women from poorer to richer countries, as Ehrenreich and Hochschild (2003) have argued, then local gender relations in this instance appear to have a less predictable effect; one which, in certain instances, may even counteract these broader transnational determinants of labour movement. Bongile's struggle over balancing her work with her role as a mother compelled her, in the end, to return home to South Africa.

### **Migration as an avenue to achieving new forms of status**

For Bongile, the benefits of migration included not only the economic security it brought her, but also the cultural capital enabled by this security. This was gained by the symbolic weight that the idea of overseas migration engendered at both work and home in South Africa. The sense of achievement for having attained wealth in England is evident in the way that she spoke enthusiastically about it:

You know what? I built a new house. I finished that house. I even invested some couple of hundred within that short period of time, you know? When you convert it to South Africa, oh, you become rich!

Here, she drew attention to the lucrative benefits of converting English currency into South African rand. On several occasions Bongile spoke about the ways in which she could use the money she made in England in order to generate more wealth. She was pleased, for example, that the South African rand devalued against the pound while she was in England, enabling her to buy even more rand with her wages. She also explained that when the pound was strong she would apply for a loan from the bank. When the exchange rate was in her favour, the bank would debit the money from her account, enabling her to benefit further from currency fluctuations. As she explained this, she told me laughing: ‘You see? You must use your head!’

This ability to be savvy with money – to manipulate, invest and convert wages – was not only important for generating additional wealth, but also demonstrated to herself and to others her skills at interacting with, and benefiting from, a transnational monetary system that was, by and large, inaccessible to most people in her social context in South Africa. Migration overseas enabled her not only to earn more money, but also to tap into a source of knowledge which was, in itself, wealth generating. Being clever, ‘using your head’, and having the skill to navigate this type of income source gave Bongile a language – and a status – from which others were excluded.

The idea of migration enabling and enhancing access to privileged knowledge related to work as well as to wealth creation. This was evident in Bongile’s comments about people’s reactions to her at work following her return to South Africa. She suggested that others perceived her as a more competent and trustworthy nurse as a result of her overseas experience:

When you expose yourself to say “I once worked in England”, they believe in you and then they trust you. [They] say, “This one knows everywhere because she has been on trans-cultural, you know, things in another country, and she managed to cope there and work and come back”.

She prided herself also in being able to assist other nurses with the knowledge that she gleaned from being in England:

I was so popular! You know, people were coming from different wards and saying, “Ok, we are working with the sister who has been to UK!” [They] said they

couldn't believe it. Everyone was coming one by one - "Hello! We heard that you've been to UK!" - I said, "Yes I've been to UK" - "Tell us how is it?"... Everybody was so interested... [One woman] asked me how to go about making the application go faster. So I just told her "you should get an agency that is going to place [you]"... She was so excited. She said, "Bongile, you know, I'm going to England!"

Bongile described similar sorts of responses from those who live in the area where she stays. The status gained through this activity was buttressed by the material possessions she was able to accumulate, particularly her house, as well as being in a position to give money away. She described their response when she gave money:

When they receive that, they will be falling, and saying, "Really? Is this all my money?! Or I should give to somebody else?!" I said, "But you did ask! That's the money you asked for!" So everybody's just, even now they just feel like saying, "don't you feel like going back again?" I said, "Ah! No, no, no!"

These examples suggest that migrating overseas offers a powerful tool for enhancing cultural capital, bringing combined associations of wealth, knowledge and professional competence to bear in a context in which these attributes are both scarce and desirable. Migration offers a means of gaining professional status, in the working context, that is not dependent upon the traditional nursing hierarchy. In this sense, it reflects an alternative claim to status, based on new mediums of wealth creation associated with the post-apartheid opening up of labour markets, which may challenge or undermine existing nursing hierarchies.

Nurses at Bethesda frequently raised the issue of working in England, often in response to discovering that I am from England myself, prompting a stream of questions about what it is like, in what ways it is different from South Africa, and how it would be to work there. This interest was partially motivated, for some, by the initial thought that I may be strategically useful in assisting them with finding work in the UK. For others, it was simply a point of general interest, as almost all knew or had heard of at least one nurse who had moved to England to work. A clear sense emerged from these discussions with nurses that migration to work overseas presented itself as a realistic and feasible career option. Although for most the final choice to migrate would involve significant logistical obstacles, all knew that the possibility of doing so existed, and that they had skills which were internationally desirable. Thus even though the large majority of nurses at Bethesda have never left South Africa themselves, migration

played a significant role in regular social discourse at Bethesda, as an idea, a feasible career option, and an aspiration which, for some, would be actualized.<sup>157</sup>

This sense of achievement associated with migration is perhaps all the more significant given the historical features of this former ‘homeland’ area, in which the movement of people was coerced and heavily monitored by the government and – for many women especially – restricted. The differentiation of women and men with regards to labour movement has a long history in the region. As early as 1889, when the first large-scale migration took place following the annexation of Zululand to the British in 1887 and the subsequent inception of hut-tax the following year, women were required by the government to be identified by a man known to the pass officer before they were permitted to leave Zululand. This policy amongst others, Jeff Guy suggests, was an attempt to maintain and reinforce women’s role as reproducers of the homestead (Guy 1982: 180-1). Such a method of pursuing colonial aims of capitalist development and labour extraction by upholding those ostensibly ‘traditional’ features of Zulu social organisation that assisted these aims, was a technique deployed repeatedly – albeit in a variety of ways – by successive colonial and apartheid governments. The manipulation and reinforcement of particular gendered roles was an important part of this process. Male migration was more common in practice, and at an ideological level seemed to fit more consistently with the norms of family structure and – in contrast – migration of women seemed rather to have been associated more with family breakdown. Anne Mager describes a similar tendency in the Ciskei reserve in the 1940s and 50s, where ‘male discourse constructed women who went to town as subversive’ (2001: 270). Such associations, as we shall see shortly, reappear in contemporary discourses.

Yet despite its heavily coercive aspects in South Africa historically, migration had nevertheless become an integral feature of life, a means by which many households subsisted, particularly given the deteriorating conditions in rural areas and the decreasing reliance on subsistence farming throughout the first decades of the twentieth century. Migration has come, therefore, to represent an important means of wealth creation and holds a symbolic weight that is perhaps intensified by its historical centrality. Ironically, however, the opening up of labour markets and the greater

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<sup>157</sup> Several of the nurses with whom I spoke expressed negative ideas about migrating overseas that consisted mainly of fears about the perceived dangers of foreign countries, including disease and war. The image of nurses returning to South Africa ‘in a coffin’ from England was evoked on several occasions by nurses. Such fears were mentioned briefly in Chapter 3 during an interview with the staff nurse Thandeka.

flexibility of movement enabled by the post-apartheid shift to free market economic policies has meant – for many – a deepening situation of grave employment uncertainty. For nurses, in contrast, it has led, albeit only briefly and sporadically, to an opening up of the national and international labour market in which the significant demand for their skills presents itself as a world of opportunities, offering the chance of participation in the ‘global marketplace’. Many students therefore, whilst disgruntled about poor wages, talk with excitement about embracing professional life, ‘climbing the ladder’, and travelling overseas in search of ‘greener pastures’. Whether these aspirations are to be fulfilled is perhaps more doubtful, but as students who are already earning a wage, their situation is, even now, a far cry from that of many of their peers.

The image of international migration as the ultimately desirable career option is offset, however, by other concerns, introduced earlier in Bongile’s story. Many nurses expressed a wish to move overseas, but claimed that they were unable to do so because of obligations at home, most often involving the care of their children. One nurse, Ntombifuthi, who had trained at Bethesda in 1970 and spent most of her working life there, told me that when many of her friends recently moved to England to work, she had also considered doing so: ‘People said to me, “look you’ve got what they’re looking for, why don’t you go?!” ’ Having worked for many years, she was extremely experienced and highly qualified, with certificates in Midwifery, General Nursing, Occupational Health, a Degree majoring in Nursing with Community, and a Diploma in Financial Management. She explained: ‘I couldn’t because of family commitments. I had to look after my son. It would have been impossible to leave him, and my husband wouldn’t have coped.’<sup>158</sup> She said this, laughing towards the end of the sentence, which prompted me to ask further about the uneven workload at home which she appeared to imply by her laughter. She told me that she looked after their son, or sometimes paid someone else to when she was too busy. Her husband did not help in this way, she explained, drawing on a typical representation of African masculinity to account for his behaviour: ‘This is Zulu culture. This is how things are.’ Without these family commitments, she admitted, she would definitely have gone to England. But she added: ‘It’s not just about money; family is important too’.

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<sup>158</sup> Ntombifuthi’s eldest son, to whom she refers here, has severe physical and learning disabilities and therefore requires ongoing and intensive care.

As this example suggests, migration is often viewed by nurses in terms of a choice between money and family, between financial acquisition and other forms of value or self-recognition. Another nurse put it: 'I want to stay with my family... I would rather stay at home and eat peanuts'. Migration therefore symbolises for many a choice for money over and above one's family. This implicit discourse amongst nurses often downplays the fact that many women move precisely *because of* a need to support their families. In this sense, the choice of whether or not to migrate is not necessarily a choice between gaining wealth and caring for one's family. This choice, as emerges from Bongile's story, only in fact becomes a moral dilemma for an individual nurse depending on her situation at home. In many instances where there is someone at home to take care of children, both can be achieved. Indeed, in the absence of husbands or fathers, it is women who support one another in order to achieve these goals, as the earlier example of Hlengiwe testified. This is again demonstrated by an account provided by another nurse, Zama.

Zama, who had worked for many years as a senior nursing sister at Bethesda, moved to England to work, because as a single mother she was struggling and needed the additional income provided by an English nursing salary. She left her children with her friend, Nomusa, who has also been working as a professional nurse and nursing tutor at Bethesda. Nomusa has a four bedroom apartment in the hospital, but mostly stays with her husband and seven year old daughter a short drive away.

Zama had originally intended to go for a year, but decided to stay longer, realising how lucrative it was. After a year of working in England, she was able to buy a house in Durban. She is now in the process of purchasing a house in Oxford, with the intention of staying for several more years. The process of moving to England was enabled, in part, by her friend Nomusa's willingness to take care of her children for the year, although this meant that Nomusa was unable to return home to her husband as frequently. Zama's three children lived with Nomusa in her four bedroom apartment at Bethesda. Looking after the children in her hospital residence, she was unable to return home as frequently to see her husband. Although Nomusa described her obligations in looking after all those children as burdensome and difficult, after a year, when their mother Zama was more settled in England, they moved there to be with her.

Zama's dilemma was thus overcome because her friend Nomusa – although with some cost to her own domestic arrangements - was able to take care of the children while Zama migrated to England. In many other instances, other family members – usually mothers or grandmothers – take care of children while women migrate. In the example of the highly-qualified Ntombifuthi, in contrast, she felt unable to leave because she needed to take care of her son, and no-one else was available to do so. In particular, she pointed out that her husband doesn't help with the care of her son. She drew on a static image of 'Zulu culture' to explain this imbalance of workload, thus making a reference to a perceived system of socially determined gender difference that is presumed to be fixed. Gender relations in the home therefore intercept nurses' career choices, and – in this particular instance – the choice of whether or not to migrate overseas, as women struggle to balance different obligations. But as Bongile's example illustrates, migration does not, as is often suggested by nurses, necessarily involve choosing between money and family. Rather, this choice is dependent on the dynamics of 'domestic struggles' and the extent of broader social networks of support.

Thus the moral undertones of nurses' assertions that often emerge in relation to migration overseas – that it is reprehensible to prioritise financial gain over family obligations – is a means perhaps of reclaiming power in a context in which migration competes ideologically with other claims to superior status based on the prevailing, yet increasingly unstable, nursing hierarchy. This existing hierarchy, rooted in earlier missionary notions of 'respectability' and cultivated by successive colonial and apartheid governments as part of a broader ideological strategy of labour management has – as previous chapters have explained – long been characterised by an excessive preoccupation with status difference based on the reinforcement of values of professionalism (Marks 1994). It is this historically entrenched hierarchy within nursing that is potentially challenged by alternative avenues to status and wealth creation emerging in post-apartheid South Africa. Thus the current creation of a moral order by nurses at Bethesda – formulated around gendered ideas of family and motherly obligation – stands in contrast to the corrupting claims to status via the accruing of wealth obtained by migrating abroad. In this sense, patriarchal structures are prevalent not only at home, but also in hospital discourse, as nurses respond to the threat of migration with recourse to a traditional image of female responsibility – as wife and



mother – in order to challenge from a moral standpoint the new status claims of migrant nurses.<sup>159</sup>

## Conclusion

In this chapter I have drawn attention to the multiple factors which might influence nurses' decisions about whether or not to migrate. These include the demands of international labour markets, the complex cultural and economic impacts of migration as a practice of major historical influence in this region, and finally the intimate networks of social relations within which individuals are rooted. The examples presented describe ways in which husbands have intervened in the career paths of nurses, with varying outcomes. Other examples demonstrate how migrants draw upon wider networks of family and friends for the tasks of childcare in the absence or unwillingness of husbands to carry out this role. Perhaps this blurring of the boundary between what we call 'domestic' and a wider social sphere could challenge the validity of Bozzoli's 'domestic struggles' concept which – by claiming to differentiate between the external and internal to the domestic – presupposes such a boundary. Yet nevertheless, without wishing to overemphasise the predominance of the husband-wife relationship, certain expectations and actions associated with this relationship still, I argue, often impact significantly on the remit of possibilities and choices open to nurses. Yet as I have shown in the case of Bongile, where women have particular access to financial and professional resources, aspects of this relationship may be challenged or even bypassed.

Given such a diversity of experiences, Cheryll Walker – as I described in the first section – has called for an analytical detachment of 'womanhood' from patriarchal discourse, criticising the idea that women should be defined first and foremost as wives or mothers. Yet these essentialized categories still feature heavily in hospital

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<sup>159</sup> Several authors have described how South African nurses' constructions of gendered identity lead them to criticise their female patients. Liz Walker, for example, argues that by drawing on their own perceived motherly role, nurses criticise women that come for an abortion, producing a 'culture of responsibility' in which 'men emerge blameless' (Walker 1996: 63). This kind of moralising attitude of nurses, predicated on validating the motherly role, reconfirms male authority, she argues, and prevents nurses from representing and supporting the needs of their female patients. Shula Marks makes a similar observation: 'Depoliticised by training that leads them to see the individual rather than the social origins of ill health, many black nurses have imbibed the commonsense racist discourse of their white mentors and have the same "blame the victim" attitude to their patients, accusing mothers of stupidity and neglect when they bring their malnourished infants to hospital' (Marks 1994: 209).

commentaries around the issue of migration. Whilst many nurses speak enthusiastically of the possibilities of seeking work overseas, others condemn migrants for abandoning or neglecting their family in the pursuit of financial gain. Drawing on fixed gender representations of Zulu masculinity on the one hand, and female domestic responsibility on the other, I have argued that these criticisms are a response to the challenge that overseas migration presents to traditional forms of nursing hierarchy. Migration is a vibrant symbol of the new and attractive possibilities available for economic participation and status groupings in post-apartheid South Africa. I suggest, therefore, that this criticism is rooted in a fear of the threat that migration presents, as a new and powerful tool for status acquisition in the post-apartheid context.

Yet a further contradiction is perpetuated, however, by the shifting international labour market that I described in relation to the UK recruitment of international nurses. As the UK increasingly experiences a shortage of skills alongside a surplus of newly qualified, inexperienced nurses – as recent trends suggest – greater conditions are placed on nurses, restricting who is allowed to enter the country to work. Such restrictions, favouring those nurses with particular specialities and senior qualifications, inadvertently perpetuates the internal professional hierarchy within South Africa, with junior nurses increasingly barred from the opportunities open to their senior colleagues. This is an example of the ways in which international and localised processes intersect, impacting on the life course of individuals in particular, tangible ways.

Whilst providing evidence of strong, upwardly-mobile aspirations amongst nurses at Bethesda, the various examples in this chapter also demonstrate the struggles taking place over the symbols of status, with international migration clearly offering its participants a powerful source of cultural capital. Such processes indicate that nursing hierarchy, as well as a wider social status of nurses, is a focus of intense struggle, and far from self-evident.

## **Chapter 8**

### **Conclusion**

Bongile's story in Chapter 7 offers an interesting example of the conflicting forces that act upon individuals, while at the same time showing that these pressures may not be as influential or their results as totalising or deterministic as they appear at first. Indeed, in this instance, they had the effect ultimately of generating greater individual assertion and purposeful action. On the surface, her story is an ordinary account of a person migrating to improve her financial prosperity. In South Africa, it is fair to say, material wealth is one of the most important signifiers of social status. Bongile showed a preoccupation with money and material consumption, aware of the status that such items offered in a context in which these were both scarce and sought after. Material well-being and financial betterment is undoubtedly a powerful motivation for behaviour in this context, and a defining feature of social relations. Yet Bongile's story demonstrates that prosperity is not only measured by material possession alone but, fundamentally, is linked to the moral values to which she subscribed. In her account, material improvement and individual moral recognition were intimately bound together in a complex set of motives that at times appeared compatible and at other times provoked huge tension.

For the nurses that attended the Born-again prayer group, similar issues were at play. Indeed, Born-again Christianity seemed to offer a powerful way of reconciling the two, both promising a means to greater material comfort whilst demanding moral scrutiny of one's behaviour in relation to a wider set of social relations and workplace issues. Both Born-again Christianity and international migration were creative attempts at pursuing material and status aspirations and at generating individual opportunity in ways that engaged with the moral concerns that nurses confronted in their daily lives. Rather than merely indicating a desire for status, they involved a process of moral self-fashioning in response to a context of profound instability and social change.

In nursing in South Africa, material and status aspirations have always been closely twinned to the search for moral standing. Indeed, the latter was itself a marker of status,

linked explicitly to a Christian mission ethos and lifestyle that provided important access to an elite class. This thesis has explored the ways in which these themes reappear in the contemporary context of post-apartheid social transformation. It has shown how longstanding debates within the nursing profession remain relevant while being mediated and refracted through tensions arising in South Africa at this particular moment.

The current time in South Africa is one of considerable uncertainty as people and groups struggle over the symbols of an emerging public discourse. While the South African government speaks the language of 'modernity' and couches its rhetoric in a vision of the future, academics and journalists typically look to the past, defacing official attempts to portray things in a positive light. As Burawoy & Verdery state in relation to European transitions to post-socialism, theories of transition are 'often committed to some pre-given future or rooted in an unyielding past' (1999: 4).

Health care is also spoken about in terms of the 'before' and 'after' of transition, and has been a focal point of such debates, receiving heightened attention largely due to the profound impact of the HIV/Aids epidemic, an ugly blemish on the face of Mbeki's 'modernising state'. Its impact upon health services, along with numerous other obstacles affecting the process of transformation, has provoked many to argue that the health system has reached a state of crisis. More than any other group, nurses bear the brunt of this situation, facing the daily strain of overbearing workload and resource shortages.

Yet below the surface of these pragmatic conditions that make the daily job of nursing extremely draining is a profound moral anxiety, finding its expression in workplace tension, competition, and struggles over status. This thesis has sought to explain these dimensions experienced by nurses working at Bethesda Hospital, which are connected both to wider historical and spatial processes and to the situational specificities of individual lives. This thesis has drawn out some of these various strands and explored their interconnections in order to examine the roots and consequences of the moral uncertainty that predominates in nurses' commentary about their work.

In the public media as well as among nurses themselves, a pervasive discourse emphasises deteriorating levels of 'care' in South Africa's health system and in nursing

in particular. Part if this has to do with low levels of motivation and a subsequently low output on wards which, if the wide literature on the topic is to be believed, is true in some measure. At Bethesda, the extent to which this is the case varies between departments, between individual employees, and from week to week. But attention to the ways in which this problem is spoken about by nurses reveals that the perception of poor care does not draw its meaning solely from the immediate experiences of work overload, but from a longer perceived trajectory of decline. This exemplifies what James Ferguson has called '*nonprogressive* temporalization', in contrast to a teleology of *progress* (2006: 190).

Many nurses account for this decline with reference to the earlier transition of Bethesda from mission to state control that took place in 1982, an event that crystallized a longer process of secularization. Archival records from this period give an indication of the doubts that missionaries felt about the takeover and, more specifically, of its feared impact upon the quality of health care in the absence of religious motivations, sentiments and values. For them, only a belief in God, and a practical application of this belief to the medical setting, could generate the kind of compassionate and integrated approach needed. This was not felt as an anachronistic relic awkwardly juxtaposed alongside the rapid developments of science and medicine. Rather, it was understood to be inherently compatible with the holistic and community-focused approach of the newly emerging global framework of primary health care. Secularization, for medical missionaries working at that time, represented not the embracing of progress, but rather its disintegration; a reversion to the short-sited and vision-lacking approach to health care that was seen to have characterised the state roll-out of previous decades.

Nursing as a compassionate and dutiful act is deeply rooted within the missionary outlook. In this respect, the secularization and incorporation of Bethesda within a national health care infrastructure challenged a key tenet of nursing and threatened to reduce it to a mechanical task. Nurses at Bethesda explicitly link their moral commentary about a lack of care within their profession to the demise of mission medicine. Older nurses in particular, I have argued, perceive that their own religious motivations are no longer relevant to those entering the profession today. This has enabled them to draw upon long-standing associations between nursing and the respectability of their own mission education in attempting to maintain the status signifiers that separate them from their junior counterparts. Yet it would be misleading

to see this commentary as purely instrumental on the part of older nurses. For them, talking about the deterioration of nursing and in particular, their loss of authority over junior nurses, is a way of articulating some important shifts in the organisation of power at Bethesda.

The government's involvement in the hospital's work when it was run by the mission demonstrated a tension between two conflicting sources – and styles – of authority. Under the mission, and to a large extent following takeover up to the change of government in 1994, the hospital was centred on the patrimonial leadership of the Medical Superintendent who, despite being accountable first to the Methodist mission and then, after 1982, to the KwaZulu 'homeland' government, had considerable control over the administrative running of the hospital. After 1994, the demise of apartheid and the dismantling of the bantustans accompanied a rapid bureaucratisation and reintegration of health services. At the national level, this process focused upon *decentralisation* as a key imperative, substantiated in the form of a three-tier system of government in which the local district was to have considerable decision-making power. But for those working at Bethesda, on the other hand, this shift felt as though control had been swiftly taken away from them and moved to a distant location. This was to do with the fact that even under the KwaZulu government mission doctors had considerable autonomy, still having the power to make most decisions and to control the daily running of the hospital.

Ferguson and Gupta (2002) have suggested that one of the defining features of the state as an imagined entity is its perceived spatial separation from, and position "above", local contexts. What looks from a macro-scale like an integration and decentralisation of power may be experienced by those "on the ground" as a stripping of authority and agency. This raises a central problem in ethnography: how does one move between the different scales of social phenomena, how does one make explicit the hidden social forces that impact upon local contexts and, in so doing, challenge the conceptual limitations of the seemingly distinct concepts of 'local', 'national' and 'global'? Mosse's notion of 'interpretive community', the network of people and organisations that fund and generate policy for the DFID development project in India that I discussed in Chapter 5, is a good example of one such attempt. Here, the idea of 'community' suggests 'locality' for what is in fact a dispersed set of parts. By identifying it in this way, Mosse is able to subject this 'community' to an ethnographic analysis alongside

the more methodologically familiar terrain of the locale. The risk in doing so is to assume a greater degree of coherency and cooperation between the parts of this 'interpretive community' than may well exist or, because of its absence from daily, observable activities, to give it the status of 'other'.

A similar risk exists in the hospital context. The danger of an ethnographic approach is its focus upon temporal and spatial immediacy and thus its potential for assuming the same bias as that held by many doctors, of morally prioritising immediate care of individuals, over the less tangible 'bureaucracy'. The latter, with its long term goals and its position 'above' the local (the clinical 'workplace'), appears less tangible and less important.

Imagined in terms of a spatial metaphor, the loss of control felt by staff at Bethesda had to do, to a significant extent, with this detachment of administrative from medical functions. The roles of Hospital Manager and Medical Superintendent became distinct, no longer embodied by one individual. This had a profound impact upon the structural organisation of the hospital: a change that is felt strongly today. Nurses in general feel increasingly accountable not to the clinical team with whom they work, but to the managerial sections of the hospital which are separated from the wards and clinics. Authority appears more distantly located than it was in the mission style of management, in which it was entirely ward-based. This is not to say that ward-based hierarchy between clinical staff has disappeared; on the contrary, several examples included in Chapter 5 demonstrated the seniority of the doctor vis-à-vis nurses and the types of actions that result from this hierarchical relationship. But it functions very differently from the strict disciplinary regimes and expectations of respect towards seniors – based on a largely take-for-granted clinical hierarchy – that characterised the mission hospital. This is an obvious point, yet what concerns me here are the ways in which this shift is perceived by nurses and the types of discourses and actions it generates amongst them.

Increasing attention in recent years to labour rights, fair remuneration, accountability and the formal eradication of racial discrimination, has had an equalising pressure on a workplace otherwise characterised by severe stratification. Older nurses thus experience this as a breakdown of the microstructures of authority that they themselves had experienced, in which their ability as senior nurses both to make decisions and to give

orders has significantly deteriorated. Nurses that claim their juniors don't follow orders because they 'have their rights now' are expressing this fundamental shift in authority away from clinical to administrative departments.

Yet this does not account fully for the anxiety apparent in nurses' commentary. By referring to the discourse of rights, older nurses indicate a perception that this workplace experience is related to wider social phenomena. The tension that exists between senior and junior nurses seems to reflect a generational rift emerging in South Africa as a whole, an expression of the moral crisis of HIV/Aids and the toll that this continues to take on young people in particular (J. & J.L. Comaroff 2004). This has to do with a wider sense of moral breakdown, often centred on youth sexuality, in which elders feel that they no longer have moral and social control of their children (Scorgie 2003). These fears seem to mesh with workplace tensions and the apparent indifference of younger nurses towards established forms of nursing hierarchy. The synonymy between these two discourses emerges most explicitly when nurses express fears about the *future* of health care if left in the hands of younger generations, concerns that seem to resonate powerfully with a wider implicit anxiety concerning the threats to social reproduction of a society paralysed by HIV/Aids (J. & J.L. Comaroff 2004). Accounted for in terms of a perceived moral decline in nursing since the hospital's mission days, the persuasive agency of this commentary is rooted both in the moral authority of the religious idiom, as well as in the allusion to a breakdown of workplace organisational structure implied by the passage from mission to state health care. In this time of rapid social transformation, concerns based upon apparent nostalgia for the past are, in fact, saturated with apprehension and concern about the future.

The bureaucratisation of health services and the subsequent shift in institutional structures of authority affects not only the experiences and perceptions that people have about work, but also the types of behaviour in which they engage on a daily basis. Once again, this has to do with the separation and distancing of managerial practice from the medical side of health care. Managerial staff are perceived by nurses and doctors as being absent from the ward, 'up there', and 'shut away' in their offices, pen-pushers who have little understanding of the daily work carried out on the wards. Communication between medical and clinical spheres takes place, to a large extent, inside meetings and via a mass of paperwork of various kinds. It is these idioms, rather than face-to-face contact on wards, that increasingly constitute channels of authority



through which orders are given, policies distributed and service information collected. These mechanisms have intensified in a context in which ‘accountability’ has become a central principle of public services. The need to concretise procedures in document form is central to this, and is often criticised by clinical staff as having taken priority over actual clinical practice itself, once again fuelling the idea of deteriorating levels of care. Despite this undermining of the legitimacy of these new styles of accountability and audit, nurses nevertheless do have a genuine fear of such mechanisms, and respond as effectively as they can by pursuing paperwork, sometimes even at the expense of other work.

The frequent references to rights suggest disillusionment with the apparent outcomes of post-apartheid liberal democracy. The concepts of ‘rights’ and ‘accountability’ both appear, in different ways, as ineffective; somehow failing to fulfil what they are supposed to. The inexorable gap between the rhetoric and the practice of such ideals is a clear point. What is less frequently commented upon is the *form* of accountability (i.e. accountability *to whom* and *for what*) facilitated by a public sector modelled increasingly upon business principles and practices. Haque states the problem as follows:

The accountability of public governance for market-based performance does not necessarily imply its accountability for citizens’ rights, its accountability for competition and productivity does not guarantee its accountability for representation and equality, and its accountability for higher profit does not connote accountability for welfare and justice (Haque 2000: 602).

The distinctions raised in this statement go some way to explaining the seeming contradiction that, as accountability is ever more prioritised on government agendas, certain channels of political accountability appear simultaneously to be in decline (Wenzel 2007). This highlights the dangers of uncritical trust in the *principles* of democracy that can so easily slip into the realm of rhetoric, disguising the content and form through which these are ostensibly realised. As Englund writes, ‘normative approaches often become entangled in the very rhetoric that needs to be scrutinized’, and warns against ‘isolating political freedoms as the essence of democracy’ (Englund 2006: 12).

In practice, rather than having the levelling effect that these values espouse normatively, they seem to be reinterpreted in such a way as to reinforce workplace competition and hierarchy, demonstrating the uneasy and unpredictable translation of concepts and

policies into practice. Francis Nyamnjoh observed this competitive struggle over dominant political idioms:

Being a rights-bearing individual ceases to be as automatic in reality as is claimed in principle... For those who succeed after hard struggle, the tendency is to monopolize opportunities, since it is, quite paradoxically, only by curbing the rights of others that advantages are best guaranteed in effect (Nyamnjoh 2004: 34).

At Bethesda, it is revealing that a *rejection* of the idea of rights is an expression both of the desire for a form of authority that used to be more readily taken for granted, and of disillusionment with the current political moment. This is inseparable from a sense of nostalgia for a perceived past. The redrawing of history to give meaning to current situations is pervasive in many social contexts throughout South Africa, and constitutes ‘an anchor-point for the articulation of identity’ (Scorgie 2003: 185).

Hence nurses feel nostalgia for Bethesda’s missionary past, despite the political upheavals that impacted heavily on the region during that time, the restrictive laws of bantustan policy, and the draconian principles by which mission hierarchy was organised. In a more subtle way, nurses that criticise migrants for abandoning their families similarly claim recourse to familiar ‘Zulu custom’ that naturalises women’s roles within the domestic setting. In contrast to such discourses that are rooted in ideas of the past, international migration and Born-again Christianity are practices which – although drawing on established themes of migration, Christian respectability and gender – enable the creation of opportunities that are felt by their participants as new and exciting. In different ways, they both represent a rejection of representations of social and professional deterioration and moral decay. Rather, they offer ways of conceiving of futures beyond the liminal uncertainty that characterises the politics of transformation.

## Appendix A

### Socio-economic and healthcare indicators for Umkhanyakude District

Umkhayakude District Municipality	2003/04	2004/05	2005/06	2006/07	2007/08	National value most recent
Population total			578 718	586 984	593 551	47 844 347
Access to piped water (%)			46.8	40.4	58.0	85.8
Deprivation index - (high value = most deprived)			4.72	4.63	4.49	
Socio-economic quintile - (1=poor, 5=best)			1	1	1	
Nurse clinical workload		42.9	24.5	23.5	22.1	23.7
Average length of stay	7.9	8.2	7.0	6.7	6.6	4.4
Bed utilisation rate	62.1	64.3	64.1	65.0	69.0	65.3
Clinic supervision rate				22.9	67.2	48.2
Male condom distribution rate	9.6	10.0	9.7	11.7	10.5	11.8
Immunisation coverage < 1 year	75.1	77.1	85.9	85.3	78.9	84.2
HIV prevalence among ANC clients tested (DHIS)	30.5	30.4	30.8	20.0	31.7	24.4
HIV prevalence among ANC clients tested (survey)				36.3 (31.7-41.0)	39.8 (35.0-44.8)	28.3
Delivery rate in facility	65.5	79.2	79.5	79.7	78.8	80.6
Stillbirth rate	28.3	21.3	20.1	19.1	16.0	23.0
Perinatal mortality rate in facility	38.1	27.9	27.3	28.3	21.6	31.1

Source: Day *et al.* 2009. *District Health Barometer 2007/08*. pg.168

# **Appendix B**

## **Bethesda Hospital Management Organogram**



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