HOSPITALS, PATERNALISM AND HEALTH CARE IN THE REPUBLIC OF SOUTH AFRICA – A PERSPECTIVE ON HOSPITALS AS PATERNALISTIC INSTITUTIONS

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INTRODUCTION

The concept of paternalism will be defined. Then military and missionary hospitals will be discussed as paternalistic institutions, followed by references to paternalistic political and economic influences on hospitals and health care in the RSA. Paternalism in training schools for doctors and nurses, as well as in hospitals and health care services in the RSA will be illustrated, followed by suggestions for improving health care for the RSA's population by recognizing and addressing paternalism in the RSA's hospitals and health care systems.

'Pater' is a Latin word meaning 'father', thus paternalism implies fatherly control which 'limits the freedom of the subject by well-meant legislation' (Concise Oxford Dictionary, 1967). This implies that paternalism embodies a principle of altruistic kindliness, to the extent of meeting another person's needs even against the wishes of that person; or refusing to acquiesce in his or her wishes for the person's own benefit – as judged by the paternalistic person (Childress, 1982:12). A paternalistic person makes decisions on behalf of other persons for the other persons' own good, with or without consulting them, and with or without their permission, in the same way that parents decide what their children may or may not do.

'Acting in the patient's best interest' could be regarded as the most important prerequisite of all medical interventions. In no other way can health care workers justify pushing needles into people, cutting them with knives and blades, exposing them to harmful radiation, pouring fluids into their veins and suturing their bodies with needle and thread. All these, and other actions are justified because they are directed towards '... helping those in need of aid' (Häyry 1991:3). All health care professionals, including nurses, can and do act in paternalistic ways – not only towards their patients/clients but also towards each other both interprofessionally and
intraprofessionally. However, the best known paternalistic behaviours in the health care system, usually operate between doctors (presumably well educated domineering men) and nurses (presumably less well educated subservient women). As more and more females do become doctors, and as a limited number of males do become nurses, it might be linguistically more correct to refer to ‘parentalistic’ behaviour rather than ‘paternalistic’, but for the sake of this paper the word ‘paternalistic’ will be used.

A hospital is usually regarded as an institution where the sick and wounded receive medical treatment and nursing care. Throughout the world, including the RSA, hospitals have been established as a result of military, religious, political or economic considerations. The paternalistic influences in each of these types of hospitals will be briefly addressed.

MILITARY HOSPITALS

The military structure of a country might be the most male-dominated paternalistic societal institution in the entire country. The ultimate purpose of the military could be seen as organized killing, in sharp contrast with the healing, nurturing and caring services of female nurses (Roberts and Group, 1995:101). Yet wherever men fought wars, nurses followed to tend to the sick and wounded, often in tent hospitals and with limited equipment. Indeed the Crimean War offered the historically noteworthy opportunity to Florence Nightingale to prove to the world that nursing care could succeed in reducing the death rate at Scutari from 42% to 2.2% within six months (Dolan, 1969:215). Although Florence Nightingale never challenged paternalism in the hospitals or health care systems, she brought about this dramatic decline in the death rate at Scutari not by rendering nursing care to individual patients only, but also by managing to obtain and control supplies, improving the diets, establishing and maintaining drains and sanitation. Moreover, she submitted regular reports to the appropriate authorities and to the media of the day. She used at least the mechanics of economics, politics and management (usually regarded as male attributes) in addition to her nursing actions (typically regarded as ‘caring’ female attributes). Lavinia Dock, one of the first nurse feminists, stated: ‘Women’s autonomy had been lost...when men took control of the health care systems in the seventeenth century, bringing general contempt
to the nurse and misery to the patient until Florence Nightingale came to
the rescue' (Roberts and Group, 1995:81).

Statistics of the Crimean War illustrated the significance of providing ade­quate nursing care to the sick and wounded. On the other hand, statistics from the South African War (1899–1902), waged between the British and the Boer forces, illustrate the disastrous effects which could result from absent and inadequate health services, including nursing services. These statistics, it should be kept in mind, refer not to wounded nor to sick soldiers, but to healthy women, children and elderly people concentrated into camps spread throughout the Boer Republics. They became ill and died as a result of lack of basic amenities, exposure to the cold and to infectious diseases, and to a lack of nursing and medical care. A total of 27 927 deaths (including 5 553 children) were recorded in the concentration camps. The actual number of deaths might have been much higher as recording of deaths commenced after the camps had been established for an unknown time, and ceased before all the camps had been vacated. Many deaths could have been prevented if more doctors, medical supplies and trained nurses had been available. Much illness and many deaths could have been prevented by merely isolating patients with measles, diptheria or typhoid from all other people, by regularly cleaning the camp hospitals and by improving the diets of the people in the concentration camps (Searle, 1970:220–224). ‘It became necessary to bring back medical officers who had retired ... these hospitals were not always properly orga­nized or supervised... Moreover, there was a tendency .... to treat the hospital too much like a barracks and to regard the patients too much as soldiers and not enough as patients’ (Searle, 1970:185). This militaristic paternalism, ordering patients and nurses as to what to do, and failing to obtain the necessary medical supplies, contributed towards the high inci­dence of deaths during this war waged on South African soil.

During the First World War, nurses could be regarded as leaders of all women, but during World War II, ‘ ...the nurses, who paved the way for other women, fell behind them, probably in large part as a result of their subordination to physicians’ (Roberts and Group, 1995:132). However, the long term positive effects of World War II included that female nurses became fully commissioned for the first time in history, implying that nurses could really manage the nursing care rendered by themselves and by the
enlisted corpsmen (Roberts and Group, 1995:13). For the first time in history, nurses with the ranks of officers, were not compelled to take orders from soldiers who were officers.

In military hospitals, paternalism reigned, and continues to reign supreme, nurses having to accept orders not only from the doctors but also from army officers, with ranks more senior than those of the nurses concerned – which could not always be in the patients’ best interest. Similar paternalistic developments took place, and probably continue to persist, in many missionary hospitals.

MISSIONARY HOSPITALS

As more and more missionaries entered Africa, more and more missionary hospitals were erected. Although these missionary hospitals rendered health and nursing care to the local populations, the ultimate aim was to reach peoples’ souls to convert them to Christianity through tending to their health care problems. Ministers of religion, or priests, were often the unofficial, but sometimes even the official, overseers of these missionary hospitals. Nurses from both the Anglican and the Catholic sisterhoods helped to establish nursing services in this country. Indeed the first South African nurses were trained by an Anglican nun in Kimberley. To be admitted to the training school, the young women had to be ‘... ladies in every sense of the word and God-fearing women above all else’ (Searle, 1970:143). Although these sisterhoods rendered major contributions to the people of this country, they also instilled in nurses the so-called female virtues of obedience to authority, hard work, little if any remuneration and ‘... the grace of a special dedication of lives devoted to their fellowmen ... a concentration of all their energies on the highest conceivable objective – enthusiasm and absolute faith in what they were trying to do’ (Searle, 1970:152). Nurses trained at Kimberley started training schools all over the country, promoting these attitudes of humility, service and unquestioning obedience among their nursing students and staff. These teachings ensured that ‘good’ nurses obeyed orders from doctors and missionaries – another form of dual paternalism in some South African hospitals, serving to disempower nurses. With the attitudes of obedient ladies strongly entrenched in many nurses even to the present day, it
could be understood why so few nurses in the RSA seem to be able and willing to voice their professional standpoints; and equally few to join or even to attend feminist activities in the RSA. This apparent lack of professional assertiveness among nurse leaders in the RSA, becomes especially visible in the political arena.

**HOSPITALS AND POLITICS**

Health could be regarded as a political decoy when hospitals and/or health care facilities are established in communities not supporting the ruling party just prior to political elections. The message could be communicated to all voters that the ruling party cares for them by providing health services, and thus deserves their votes.

Another political use of hospitals is to name a hospital after a political figure. Whether or not one opposed apartheid, if ill, and referred to the currently known Pretoria Academic Hospital, but previously called ‘H F Verwoerd Hospital’, one would hear and see the name H F Verwoerd on numerous occasions throughout one’s hospitalization, implying that the master of apartheid was instrumental in providing medical and nursing care when one really needed it.

After the African National Congress (ANC) came to power in 1994, free health care for all mothers and children up to five years of age was announced. This was certainly a commendable political step to take, but it could have been so much more commendable – and feasible – if the health services, and especially the nurses responsible for providing most of these services, had received prior notification, improved staffing of health facilities, increased budgets and especially increased supplies of medicines. This ‘free health service’ might disempower and disillusion many nurses who need to render services to many more people, without the necessary staff, facilities, equipment or drugs. The only way in which nurses could prove their need for more staff, more equipment and more medicines, would be to compile statistics of the work loads before and after the announcement of free medical services. Unless nurses can succeed in statistically proving their increased workload, health care planners will continue to assume that the services cope with the available facilities and equipment.
Since politicians determine health care policies, allocate health care budgets and decide where and when health care facilities will be expanded, they influence the health care system both directly and indirectly. Unless nurses, who constitute the largest number of health care workers in the RSA, begin to understand their role as nurses and as females in both the paternalistic health care system and in the paternalistic general political system of the country, they cannot begin to improve the situation for the nursing profession in the RSA. It could be impossible ‘... for female nurses to implement expanded roles if they are unaware of or unwilling to recognize the social constraints imposed on them because they are women’ (Roberts and Group, 1995: xi).

In the case of nurses these social constraints include the previously discussed paternalistic military, missionary and political decisions being enforced on the health care providers. However, paternalistic economic considerations continue to exert an increasingly important influence on all health care services, including nursing services.

HOSPITALS AND ECONOMICS

Health care and hospitals have become big business in many developed countries, especially where prepaid medical insurance schemes virtually guarantee health care providers and hospitals to be paid for services rendered to their members. The RSA is no exception with more and more private hospitals arising in all cities and even in the larger towns of the country.

The only reason why people get admitted to hospitals is to obtain nursing care – otherwise they could get discharged from the operating tables. Hospitals, including private hospitals, are established by doctors, businessmen or politicians to offer nursing care to patients. Yet nursing care is not reflected on patients’ hospital accounts. Patients pay per day per bed, for medicines, bandages, minutes spent in theatre and get separate accounts from the surgeon, anaesthetist, pathologist, radiologist and physiotherapist – but no account from nurses or for nursing care. When discharged patients feel dissatisfied with their nursing care, they blame the nurses, but when they perceive the nursing care to have been of a high standard
they attribute this to 'good orders from the doctor(s)'. Nursing care thus becomes invisible, and of no economic consequence, not only to the patients but also the hospital managers who may regard the hospital's rate of bed occupancy and the maximum occupation of the operating theatres as generators of the hospital's income. However, without nurses to provide nursing care, the hospital beds and the operating tables would not generate any income whatsoever.

Nurse managers in some institutions, not only in the RSA but also in the USA, still do not compile nor control their own budgets, even though the nursing service manager controls approximately 80% of the personnel budget of most hospitals (Roberts and Group, 1995:198). Nobody can manage a service without money, without a budget. However, if nursing service remains economically invisible because hospitals do not charge for nursing services, then hospital managers might be excused for regarding nursing services as being the major expenditure of the hospital, without bringing any money to the institution – when indeed nursing is the only reason for hospitalizing patients.

Nurses need to realize that in addition to being committed to service and to the welfare of their patients, they also need to become expert with regard to economics and accountancy. With such competencies they could demonstrate the worth of nursing care, in rands and cents, for a specific institution, otherwise nursing will remain invisible economically, and unable to claim its share of the health care budget of any institution, or of the country as a whole. Unless nursing managers can succeed in these aspects, nursing services will have to remain satisfied with the inadequate budgetary handouts received from health care and hospital administrators as calculated by them with, or even without, consultation of the nursing service managers. In addition to paternalistic military, missionary and political issues, paternalistic financial decisions influence the quantity and quality and affordability of the RSA’s health services.

HOSPITALS AS PATERNALISTIC INSTITUTIONS

Hospitals and other health care services, whether established for military, religious, political or economic reasons, seem to harbour at least two
paternalistic systems, making decisions on behalf of patients, and issuing orders to nurses and/or patients. Depending on the type of hospital, the nurses receive orders not only from doctors, but from army officers, missionaries, politicians or economists, or a combination of these paternalistic authorities. Thus the nursing profession has been aptly described as itself being ‘... sick, suffering from an illness caused by the medical and hospital care it had received over many years’ (Ashley, 1977:70). Unless nurses become aware of, and address, these paternalistic influences, the nursing profession and the health care system of the RSA cannot reach independence, and might remain crippled by paternalistic authoritarianism, making decisions not only affecting nurses and hospitals but the RSA’s entire health care system. The feminists of the RSA could be of assistance to the nurses of the RSA in this regard, provided some mutual co-operation could be established between these two groups of women.

One of the reasons why the nursing profession in the RSA seems to fail to recognize the paternalistic influences on the health care system, might be that the majority of nurse leaders have been trained in paternalistic hospital training schools.

PATERNALISTIC HOSPITALS AS TRAINING SCHOOLS FOR NURSES AND DOCTORS.

Hospitals exist to provide nursing care. Thus hospitals with schools for training nurses can provide nursing care (rendered by the student nurses as part of their ‘practical’ training) at extremely low costs.

Numerous problems arose out of this apprenticeship approach to the training of nurses, as each hospital could offer as much or as little training as its administrators wanted to offer. Although there were many commendable hospital schools for training nurses, exploitation of student nurses did occur. In most hospital schools paternalistic attitudes prevailed in requiring subordination of authority, obeying all hospital rules, being loyal to the hospital and in conducting themselves as worthy members of the noble profession of nursing. The apprenticeship system under which nurses trained in the RSA, and in other countries including the USA ‘... instilled a strong faith in superiors, a desire to cooperate and a tendency
to think less of oneself and one’s own needs ... and promoted dependability and efficiency in carrying out assigned responsibility’ (Styles, 1977:8). In this way student nurses were isolated from the mainstream of the country’s education system and from other students. As an isolated group of students, constantly subjected to paternalism in hospitals, nurses became socialized with the idea that they existed to serve other people (doctors and patients) and an institution (a hospital). ‘In nursing, it became obvious that it would be improbable, if not impossible to prepare assertive, independent nurse practitioners if they were socialized to be dependent females’ (Roberts and Group, 1995:xii).

Although the South African Nursing Council (SANC) proudly announced major improvements in the RSA’s system of nursing education, with major changes taking place since 1983, independent research is awaited to confirm the success of these changes. The problem which remains in nursing education, is that student nurses are still being trained in paternalistic hospitals, and taught by professional nurses themselves trained by an approach resembling apprenticeship training – enforcing a respect for rules and an obedience to authorities – with its inhibiting effects on stimulating questioning minds in an effort to obtain true professional autonomy. In this way paternalism in most hospitals of the RSA could continue to exist.

All nursing education, including courses offered by universities, needs to be revised, democratized and liberalized. Nurses do follow undergraduate and postgraduate courses at most South African universities, but their choice of subjects is usually limited to a variety of nursing courses with optional subjects from the social sciences, especially sociology, though sometimes psychology, philosophy and anthropology are also offered. Empowering women, including nurses, requires a liberal education. It is time that each nursing department at the various RSA universities, realizes that nurses need knowledge of economics, education, politics, languages, law, accountancy, physical sciences, and possibly many other disciplines, to become empowered to negotiate effectively with policy makers, hospital and health care managers, and with doctors. As no one person can be an expert in all these diverse fields, each nurse who pursues university studies at great personal cost, should be enabled to choose alternative subjects suitable to his or her unique situation, interests and/or abilities.
Nurses doing the BACur degree at Unisa, were previously forced to do Sociology II, but they will be able to choose from among a number of courses offered at this university to be taken up to second year, even up to third year level, should the individual student prefer to do this, with the implementation of the modular system as from the year 2000. This would seem to be the most efficient and quickest way in which nurses could acquire more expertise from various fields; become more empowered and reduce the influence of paternalism in the health care services in the RSA. However, paternalism continues to influence health care practices in the RSA in various ways.

PATERNALISM AND HEALTH CARE IN THE RSA

Most health care services are rendered by nurses throughout the country, but especially in Primary Health Care (PHC) facilities. Unless PHC providers recognize and address paternalistic influences limiting the effectiveness of their daily health care practices, the effectiveness of the entire country’s RSA’s PHC remains unlikely to improve.

According to the ANC, the RSA’s national health service must be driven by the PHC approach (ANC 1994:45). However, all health care professionals, including nurses and doctors, still spend much more time in hospitals than in PHC facilities during their training. This might be attributed to the ease of supervising large numbers of students in hospitals and the difficulty of doing so in scattered PHC facilities, or to the greater comfort experienced by the paternalistic decision-makers because they acquired their clinical experiences mostly in hospitals.

Another major problem in the PHC arena appears to be the lack of accurate information about the actual costs involved in realizing a governmental commitment to provide adequate PHC services (Broomberg and Rees, 1993:275). If PHC is the focus of the current health care services, then it should also become the focus of the students’ training programmes, otherwise newly qualified health care professionals could regard primary health care as irrelevant, or perhaps as peripheral to their training, and thus to their professional practices. This conception might contribute to the large numbers of qualified doctors and nurses leaving the RSA, who completed the major part of their training in large hospitals but are expected to function in
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PHC settings subsequent to obtaining their qualifications. The reduction of mortality and morbidity rates in the RSA might be more dependent on improved education for women, access to clean water and adequate food supplies than on health care services as such. However, in an effort to provide PHC services to the RSA's people, medical students are legally required to render one year's community service upon successful completion of their training — another paternalistic decision influencing the health care services in the country. Although similar community service is not yet legally required from nurses, in many parts of the country the only available nursing posts are in rural PHC services. This forces many newly qualified nurses to accept these PHC nursing positions in the RSA or to seek nursing appointments in foreign countries, where health services' requirements might match their training experiences more closely than those inside the RSA.

Some problems encountered in rendering health care to the population of the RSA, especially PHC services, could be attributed to the paternalism prevailing in many hospitals, medical and nursing schools. According to paternalistic medical approaches, the doctor not only knows best, but may function within a Westernized medical paradigm, with little or no exposure to any other culture, or any other health care system. Such an attitude could create tensions between what the patient (who might already have consulted traditional healers) expects and what the doctor believes the patient needs (in terms of his/her education in Western medicine).

Conflicts between medical paternalism and patient autonomy cannot benefit any health care system. Health care professionals who come from cultural backgrounds different from those of their patients need to accept and respect the patients' cultures to achieve any success whatsoever with treatment and health education. This can be a most difficult achievement in the RSA with eleven official languages and numerous subcultures. To complicate health issues further, many doctors working in the National Health Services are foreigners coming from countries such as Cuba, and Spanish is NOT one of the RSA's official languages.

Nurses who are familiar with patients' cultures could play a major role in providing health care and health education acceptable to individual patients, and benefitting their health, by both accepting and respecting cultural taboos and practices such as not eating eggs while pregnant; preparing and eating
indigenous foods, foreign to Westerners, such as mopani worms; consulting the traditional healer prior to visiting the clinic or doctor; requiring the traditional healer to perform certain rituals prior to undergoing surgery; and accepting the importance of the forefather spirits in disease etiology.

Especially in the field of maternal and child health care, nurses conversant with both the Western medical paradigm and the local culture, could render valuable inputs in educating not only the patients/clients but also the other members of the medical team, including doctors. Health education approaches which accept and respect cultural issues, such as the importance of a large number of children to many families, decidedly have a much better chance of achieving success than those who discredit the importance of cultural issues. ‘Child spacing’ programs, enabling families to have as many children as they wish but also spaced as they desire, seem to be much more acceptable than programs advocating fewer children only.

Nurses who are knowledgeable about both Western medical treatment and traditional health can identify cultural practices which enhance health status, such as breastfeeding a baby for two years; not drinking water from a source covered with green algae. They will recognize customs which have no effect on health care such as placing ‘weaning bracelets’ around the arms of toddlers in the process of being weaned, and those which definitely threaten health and possibly even life, such as rubbing cow dung into the umbilical stump of newborn babies; or male (and even female) circumcisions being performed under unhygienic conditions.

Health education efforts should not only decry those traditional practices which threaten health but also reinforce those which enhance health. However, it is unlikely that paternalistic health care workers will succeed in doing so; they are more likely to tell patients which practices should be discontinued ‘for their own good’.

With the help of nurses, it should be possible to determine the real beliefs concerning AIDS (acquired immuno-deficiency syndrome) in each community. Most health education efforts concentrate on the necessity of practising safe sex with only one partner – a rather paternalistic way of telling people that abstinence is good for preventing AIDS, but that sexual relations with only one partner is also acceptable for ensuring health. This
is a foreign concept to many traditional Africans who have been practising polygamy for centuries. The use of condoms to prevent the contraction or spread of AIDS, is an emotional issue requiring much research to make health education more meaningful to specific target populations. Women in most cultures including those where female condoms might be available, would seem to be at the mercy of men’s willingness to use condoms for the protection of both partners against AIDS. However, many people might find it incomprehensible to use condoms, to prevent contracting AIDS, which causes deaths mostly from tuberculosis or pneumonia (as a result of the impaired immune system). There is no obvious connection between not using condoms and dying from respiratory tract infections, unless the intricate etiology of AIDS can be understood. Mere paternalistic health education approaches like telling people to use condoms for their own good are unlikely to succeed in changing people’s behaviour.

In order to render an effective primary health care service to any specific community, nurses need to recognize and address paternalistic issues not only relating to the health care system, nor only to doctor’s orders, but also those affecting men and women in the community concerned. If men are the primary decision makers concerning the size of their families, it would seem to be inappropriate and ineffective to direct family planning motivation talks to women only. Unless paternalistic issues are recognized and addressed (preferably with community participation) the best efforts in rendering PHC services may amount to a mere waste of time and effort. However, health services will benefit more people in the RSA, if paternalistic issues could be recognized and addressed effectively by the health care workers and the communities concerned.

SUGGESTIONS FOR IMPROVING HEALTH CARE FOR THE RSA’S POPULATION

Wildavsky (in Muff, 1982:256) maintains that ‘Medical care alone does not equal health. The best estimates are that the medical system itself affects about 10% of the usual indices for measuring health, i.e., where you live, how well you live, how long you live. The remaining 90% are determined by factors over which doctors have little or no control, such as individual life style, social conditions, and the physical environment’.
More (paternalistic) hospitals and more (paternalistic) doctors might thus not succeed in providing health care accessible and acceptable to the RSA's entire population, but more effective PHC services can succeed in attaining this goal. Such services need re-organization of the available (wo)manpower and funds. Since most PHC workers are nurses, this source of womanpower needs to be empowered to render PHC services. Empowerment of nurses involves that nurses need to change their attitudes towards themselves and towards the nursing profession – which could be facilitated by a more liberal nursing education. The link, apparently lacking in the RSA, between nursing and feminism needs to be established. Nurses in the RSA have not been involved in feminist issues and movements, probably due to their training in paternalistic environments which did not sensitize them to feminist (nor to paternalistic) issues.

Many nurse leaders in the RSA still seem to be influenced by Victorian ideas about 'nice women' who should be 'ladies', often seeming to be subservient when assertiveness is needed to solve nurses' problems. Nurse leaders, and many nurses, have not seemed to view political activism as either a virtue or a necessity.

The spokespersons for the RSA's nurses frequently appear to be trade unionists not nurses. Perhaps this apparent failure of nurse leaders to lead the nurses in effectively voicing and negotiating their problems, could be attributed to the ineffectiveness of nurses' pacifying pleas made to economically motivated and politically powerful males. 'Conciliatory attitudes and behavior... prevented any accurate analysis of their real social and political problems as women dealing with a system of paternalism' (Styles, 1977:14). What the nurses of the RSA seem to need most is to acknowledge that the majority of them are women, and need to cope with women's problems in a paternalistic health care system. Unless the nurses can succeed in doing this, it seems unlikely that they will be empowered to solve their professional problems. Empowerment, which could be defined as '... the idea of personal strength facilitated through interaction with others', might enable nurse leaders to define and control situations, rather than merely responding to problems (Porter, 1991:181).

Not all inter- and intraprofessional relational problems will disappear with paternalism (Mitchell and Oakley, 1986:240). However, male-dominated,
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economically-motivated medical practitioners and politicians will need to be convinced of the merits of empowering nurses to render more effective, acceptable and accessible PHC services. This could be the most effective cure for what ails the South African health care system. Once the paternalistic influences in military and missionary hospitals as well as in political and economic decisions affecting health care services in the RSA are recognized, then greater emphasis can be placed on women’s health issues in the RSA. 'Unless women’s health needs are met, their capacity ... will be constrained and they will be unable to realize their own potential as human beings. Many more will die prematurely and even more will have the quality of their lives diminished... women’s right to health ... must be a central concern, not only in feminist politics, but in wider campaigns for sustainable development, political freedom and economic and social justice' (Doyal, 1995:232).

CONCLUSION

Nurses, predominantly female in the RSA, need to recognize and address the paternalistic influences pervading military and missionary hospitals as well as political and economic decisions affecting health care services in the RSA, in order to enhance the effectiveness of nursing services rendered in the RSA. Provided the RSA’s nurses can be empowered, and can successfully change their attitudes towards themselves and towards the nursing profession, and towards all other health care professions, they can render more effective health care services. ‘Ultimately, the basic struggle will be accomplished when women’s values are translated by nurses into organizational contexts that force a change from patriarchal structures to ones that value the human in all people. Until ... women in nursing control their own profession ... there will continue to be nursing shortages, professional disunity and lack of autonomy ... If the services of nurses are essential, then they must be given the authority to do their jobs, the recognition and respect for what they really do, the freedom to do all they can do, and the economic support that rewards them fairly’ (Roberts and Group, 1995:335).

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The idea that the education system is gender impartial is a myth. Research has shown that gender stereotyping and discrimination in educational institutions are widespread. Of major concern is the fact that this is still rarely consciously acknowledged by society. A number of cultural and structural factors affect the status of African women in education. The three major underlying factors that have been identified are socialized stereotyping of traditional gender roles, the associated attitudes of both males and females and adult illiteracy. These function at three levels: the societal, the individual and the organizational levels.

Female oppression is a social practice that is perpetuated by sexual stereotyping from the time of childhood through to adult life. Society plays a major role in ensuring that children are brought up to maintain this cycle of gender oppression. This is one of the main factors which has contributed to the high levels of adult illiteracy in South Africa. About 45% of the adult population of South Africa is illiterate. Illiteracy is slightly more common among women than men. It is higher in rural areas than in urban areas. Jay Naidoo, speaking at the launch of a report entitled ‘Key Indicators of Poverty In South Africa’ indicated that, among other things, South Africa has a high rate of adult illiteracy, at 39%, compared to similar middle-income countries such as Thailand, Poland, Chile, Brazil, Malaysia and Venezuela (Sowetan, 1995:12).

In this paper we examine the position of African women teachers from a historical perspective. We firstly look at how gender discrimination is expressed, maintained and transmitted to new generations through subordinating practices in African societies. In addition, the effect that these underlying patriarchal societal values and beliefs have had on the woman as a teacher will be examined. Lastly we address the question of why
women teachers should be involved in empowering other women, and offer some practical guidelines as to how this can be done.

**Patriarchal Practices and Their Effects in Black Societies**

**Traditional Social Practices**

Individuals, being the products of their societies, will inevitably be influenced directly or indirectly by the social practices of their communities. In traditional African culture, gender is regarded as the primary determinant of role expectations and behaviour in individuals. However, these expectations are based mainly on stereotyped sex roles.

Culturally, the differences between males and females were and are still widely assumed to be natural and hence not amenable to change. It is assumed that women are born with 'natural roles' and should be reared to fulfil these roles from childhood. The Sotho proverb 'mosadi ke tshwene o lewa mabogo' is the dominant cultural view of women in African society. This proverb, which means a woman's status and worth in society can only be determined by her ability to do her housework and raise her children efficiently, sums up the traditional African perception of women.

Parents are the major transmitters of culture in any society. Children are socialized at a young age to learn that power and prestige are awarded on a gender basis. Girls are made aware, from a very early stage, that boys have greater access to the benefits of power and prestige because of their maleness (Carmine, 1996:3). Girls are, for example, expected to wait on their brothers from early childhood. This enforces the division of labour along gender lines.

Customarily parents would go to great lengths to ensure that their sons received an education, the argument being that as breadwinners, boys would need to earn a living for themselves and their families. On the other hand, educating a girl was not considered as important because a girl would get married and have a man supporting her financially. In many
cases if a girl was lucky enough to be allowed to go to school, the chances of her completing her schooling were quite slim. For instance, if parents were forced, due to financial constraints, to choose which of their children could continue with schooling then preference was usually accorded the boys. In other cases, a girl's schooling might be sacrificed because with both parents having to work, she had to look after her siblings. These girls learnt from an early age that their primary role in life was to help with domestic chores and look after their siblings (Mwawenda, 1994:146).

In several instances, girls were denied an education or withdrawn from school on the grounds that they had to get married. It was argued that schooling would limit these girls' chances of getting married because they would be a threat to their husbands. Parents argued that the girls' independent ways of thinking, which they would develop from schooling, would make them challenge their husbands' authority. Carmine (1996:2) describes marriage as 'an institution created by and for the system of patriarchy in which men are given power over women'. This definition fits in with the traditional cultural view of marriage in most African societies. According to custom, when a man pays lobola for a woman he makes her his sole property and she has to obey him. The man has the right to administer corrective chastisement if the woman fails to obey him. She is also not allowed to complain about it but is expected to endure hardships in silence in order to keep her family intact.

Traditionally, a woman is regarded as a minor. She has to remain under the authority of a male throughout her life. As a child, she is under the authority of her father. Later on, as a grown-up woman, she is subjected to the authority of her husband. Custom makes certain that she remains in this subordinate position even after her husband's death. Thus, in the event of her being widowed, one of her male in-laws is expected to take over as her guardian.

THE SCHOOL SYSTEM

Schools, according to Sutherland (in Te Groen, 1989:554) reinforce what children learn about gender roles in the family situation. They emphasize gender stereotyping by transmitting predominant social values that put
girls and women primarily in the role of mothers and wives. They also shape children’s and adolescent’s gender identities by making girls and boys experiences of schooling distinct.

Research has revealed that most text-books and other learning materials reflect the stereotyped view of gender roles in society. The learning material is deeply rooted within a patriarchal understanding of knowledge and learning. The impression given is that the world is composed primarily of men. Hence, these books convey a subliminal message that women are inferior and that the division of labour in gender terms is not flexible. Research studies done on most South African school text-books used in primary and secondary schools, revealed that women are rarely mentioned in these books. If referred to, the women were then marginalized or depicted as subordinate to men in low-status or ‘women’s’ positions emphasizing their domesticity. Men on the other hand were depicted prominently in high-status positions with an overwhelming emphasis on their economic power and public role. Girls would thus emerge from school with the implicit understanding that the world is a man’s world in which women take second place.

Teachers, being the products of their own societies, are also most effective and influential transmitters of patriarchal ideologies. They transmit these stereotypes through verbal and nonverbal messages which reinforce the perception that women are subordinate to men. The male-oriented curriculum within which girls are educated, subtly channels them into traditional feminine roles. For example, it has been common practice for girls to be advised to take subjects that are related to their gender. In a comparative study on subjects taken by boys and girls, Truscott (1994) found that most African girls studied subjects that prepared them for lower-paid jobs. Boys on the other hand, were encouraged to take on the manly or difficult subjects.

The school maintains gender role stereotyping by denying the importance of women and ensuring an unequal outcome of formal schooling. However, not all schools use the same stereotypes and not all teachers attach equal importance to the transmission of gender stereotypes. Furthermore, not all these stereotypes are successfully imposed on all children (Te Groen, 1989:554).
WOMEN SOCIETY AND CONSTRAINTS

GENDER REPRESENTATION IN TEACHING

Societal expectations about and stereotypes of women’s roles are carried over into the occupational settings such as teaching. Narsi (1990:16) argues that the history of women educators in South Africa is based on a patriarchal ideology which pervades all spheres of life. For instance, although black women are the largest group of professional women workers in South Africa it has been found that very few studies have been done on them (Kotecha, 1994:22). For decades teaching has been characterized by legislated discrimination along the lines of gender roles in which male leadership is assumed to be a prerogative. As a result, mobility into higher ranks has been much more difficult for women than men in the teaching profession.

The teaching hierarchy is dominated by men in both primary and secondary schools. In 1994, for instance, although women made up 76% of all teachers in primary schools, they occupied only 46% of principalships, 48% of deputy principalships and 58% of the heads of departments while 75% of them remained in ordinary teacher posts. At secondary schools they occupied only 10% of principalships, 26% of deputy principalships and 36% of heads of department (Kotecha, 1994:24).

Salaries in the teaching field have until fairly recently also been determined along gender lines and not on the principle of equal pay for equal work. Women earned far less than their male counterparts. Married women teachers were forced to be dependent on their husbands by laws which denied them housing subsidies and medical schemes because of their marital status. Their participation in the labour market is viewed as a secondary and temporary role (Te Groen, 1989:553).

Despite changes in legislation a strong culture of male dominance still prevails in the teaching field. Female teachers contend that they are not listened to nor are they expected to speak up for themselves. Young women teachers in Gazankulu cite the patronizing attitude of their male colleagues who treat them unprofessionally by referring to them as ’my little girl’. They are not supposed to question that. Only their husbands may complain on their behalf if they choose to (Kotecha, 1994:29).

In her study of discriminatory practices in schools, Sebakwane (1993:91)
found that women teachers in the Northern Province were usually assigned to teach subjects which were held in very low regard by their male colleagues. They could only teach the prestigious subjects if no male teacher was interested in teaching the subjects. They were assigned non-teaching responsibilities which were regarded as inferior by males. Management, administration and planning tasks regarded as intellectual and creative, were not easily available to them.

Although the ideas and perceptions forged in an all-male world have been mistaken for a universal reality for decades, women should realize that they play a pivotal role in education. They need to confront social norms which regard teaching as 'only professional mothering'.

In the second part of the paper we look at how these social practices have contributed to perpetuating illiteracy among women and how women teachers can address this problem.

THE ROLE OF WOMEN TEACHERS IN EMPOWERING ILLITERATE WOMEN

In this section of the paper the role of women teachers (in spite of the hardships and constraints discussed above) in empowering illiterate women will be dealt with. The causes of illiteracy among black women, reasons for promoting and providing literacy classes, constraints on literacy initiatives and then possible strategies that teachers could use to address the problem of illiteracy will be briefly examined.

Adult illiteracy has been identified as one of the major factors perpetuating the stereotyping of gender roles in Black societies. The increased emphasis on nation building and participation in democracy by the South African government (as seen in the Reconstruction and Development Programme for instance) seeks to mobilize people and the country’s resources towards the building of a democratic, non-racial and non-sexist future, and has made people become aware of how illiteracy hampers the progress of individuals, community structures, development projects and training programmes. Motivation for adult literacy is currently high under conditions of political change, democracy, urbanization and pressure for jobs. The scale of illitera-
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Illiteracy will remain high for some time – that is, until the formal school system is completely effective and school attendance is not affected by the disruption of family and community life by social conditions.

Important research questions in this context are:

- What are the main causes of illiteracy among black women and how do these influence the social status of these women?
- What role can women teachers play in promoting and providing literacy programmes for these women?
- What constraints could be expected in running these projects and which strategies could be used to avoid and overcome these constraints?

The primary value and importance of examining these questions is the insight it will lend to women teachers’ awareness of the illiteracy problem among fellow women in their communities, and the encouragement it will give them to initiate and couple literacy classes with other relevant skills projects in order to empower other women.

Entire communities are already exposed to daily unemployment, poverty, malnutrition, morbidity, famine, inequalities and oppression – patriarchal and economic. The adverse effects of high population growth and the high illiteracy rate become more apparent every day as evidenced in our pavement dwellers, street children, teenage pregnancies, abandoned babies and children, overcrowding, slums and squatting. There is a concern that African women will still remain part of the population explosion problem instead of becoming part of the solution. It is no good pointing at a woman walking along the road with a child in either hand, a child on her back and pregnant with yet another and say, ‘There goes the silhouette of Africa’ and think this problem is hers alone. It is up to literate, educated women to do something about this.

Reasons for the Promotion of Literacy Among Women

Achieving literacy could be one of the first steps in a process enabling women to take control of their own lives, to participate on a more equal basis in society, and eventually to free themselves from economic
exploitation and patriarchal oppression. Other social and economic effects of achieving high female literacy rates include an enhanced readiness to send children, including daughters, to school, and readiness to participate in economic organizations.

In terms of personal change, the effects of women's literacy include a release from fears of humiliation and powerlessness, a strong increase in confidence, and readiness to influence family decisions. In addition to these social, human and economic effects, there are many other reasons to challenge women teachers to take action in promoting the literacy education of women. The sole fact that a mother's level of education has a positive effect on her children's progress in school, should be a strong enough argument. Literate women experience liberation from isolation; they become integrated into a newer reference and support group.

In the literacy class, the woman becomes able to manage new skills, which give her a potential new role in the family. The mastering of new skills may also give her greater opportunity for paid employment, leading to relative economic liberation. With improved educational opportunities, better training and development of skills, women will be able to enter the labour market more easily.

Preliminary findings from a questionnaire sent out by the World Young Women's Christian Association to all of its member associations confirm such liberating effects of literacy. The responses show that women who received literacy training are more respected in the community and at home. They have better skills in their search for jobs and can therefore earn higher salaries. They realize that some jobs which are traditionally considered to be for men only are for them too. They have better capabilities to run small businesses and keep records on their own. They are strengthened in leadership roles in women's groups. Their political awareness, participation and organizational skills are enhanced.

In spite of the many reasons for women to participate in literacy classes, the multiple traditional roles of black women and new roles prevent them from regular attendance and efficient learning. The most immediate practical constraint is time. As has been mentioned earlier, female learners are overburdened with domestic tasks. One other effect of women's relative
isolation and deprivation of literacy is that, as compared to men, they have had very little exposure to languages other than their mother tongue. This problem is especially salient when literacy is taught in a second language, as is often the case in South Africa.

Another important constraint is that women are discouraged by the attitudes of the male teacher in adult education centres. Husbands at times even completely forbid women to take part in literacy classes because they are afraid that if women learn more than themselves, it may expose their own ignorance, and above all it may challenge their power positions within the family.

POSSIBLE STRATEGIES

Women teachers have been accused of contributing to their own subordination. Professor Gourley contends that

> 'Women must take responsibility for some of the behaviour men exhibit, because every single man for sure had a mother. What was the mother doing that she brought up a chauvinist?' (Newton, 1994:19).

Women need to change their vision of themselves instead of supporting the 'natural role' thrust upon them by society. There is no fixed way forward. South African women teachers must start involving themselves in a hands-on programme aimed at other women, a programme comprising:

- teachers teaching women to read and write;
- teachers helping women acquire new skills that can upgrade family life and open up new economic opportunities for them;
- teachers making women aware that a woman’s place is where she chooses to have it.

Teachers should, however, guard against adopting a patronizing and superior attitude. This discourages interest. A democratic and involved attitude, treating learners as equal adults and creating an atmosphere of confidence, is found to have a positive influence on attendance and results. Activities in the programme should be prioritized according to the needs
of the women and their context. Awareness of the accomplishments of successful literate women should be raised. In addition, organized visits by national women leaders committed to empowering women act as a strong motivating factor.

Consideration in all development projects should be given to making an element of women’s literacy integral to projects. Successful examples of literacy programmes show the importance of making women aware of their problem and encouraging them to participate in literacy programmes. In setting up the incentives for literacy programmes, teachers should use creative organizational and mobilizational approaches, showing that literacy is a tool for empowerment and focusing on themes which stress equal rights, the need for women’s emancipation and equal participation in all spheres of society.

The following are two examples of successful programmes that we could adopt as models for our communities:

- On a typical day in the literacy program in Mexico, women become initiators, planners and implementors. Through the help of the teacher, they are now able to list the problems they face, to generate and prioritize discussion topics, and to oversee the programme as a whole. The building in which the lessons are conducted was built through their initiatives. The women learn to cook fish nurtured in an aquaculture system they helped to develop.

- In Thailand, literacy efforts are challenging the prostitution business, which routinely exploits thousands of illiterate and impoverished women. With the help of The Laubach Literacy International Support Programme, a Thai women’s organization is pilot-testing a literacy programme that includes skills training, consciousness raising, and development of new income generating ideas, with the goal of enabling poor women to find alternatives to prostitution.

CONCLUSION

This paper has shown that, although, the importance of women is increasingly being recognized in Black societies, their subordination to men at
work and home is still largely in practice. Therefore, South Africa needs a lifelong education and training programme that is provided in many different ways, at different stages in the socialization and working stages of a woman's life, a culture marked by a commitment to a flexible gender-sensitive approach that uses whatever combination of strategies appropriate to women's needs, demands and circumstances to challenge this subordination. Women's literacy, as part of lifelong learning, is about bringing women as individuals out of the shadows and promoting equality in societies.

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SURVIVAL STRATEGIES OF RURAL WOMEN
Nompumelelo Rulumeni-Ntlombeni

INTRODUCTION

This essay explores how rural people survive despite the fact that many women are not working and men who are migrant workers seldom send money home. However, limited financial resources do not result in rural people starving to death. We begin by outlining how African communities survive and go on to show that behind these communal strategies, there is a collaborative spirit; there is a shared will to survive and tackle the development issues facing rural people.

Rural women may not have attained high levels of formal school or college education but they clearly exhibit substantial knowledge of the natural resources with which they interact. They know exactly what plant to use for specific medicinal ends and what plants may be used as vegetables. In order to assess the contribution they make to the survival of their families, the family's income will be looked at. The term 'income' will not be restricted to earnings in monetary terms but will also include non-monetary items like the contribution that is made by women through their labour, to keeping their families alive.

COMMUNAL CONSCIOUSNESS

Disadvantaged or marginalized groups anywhere in the world survive on collective unity or solidarity, and find strength in their consciousness of being part of a group. Due to the poverty of their material circumstances they cannot survive on individual initiative only. They have to stick together on selective survival issues and unquestioning conformity is expected from everyone.

The most pervasive and fundamental collective experience of African people is their sharing of a common context and lifeworld. The experience of their shared environment is integrated into all aspects of their lives on a
daily basis (Mbigi et al, 1995). In rural villages there is no such thing as permanent job security based on continuous skills acquisition but those who have got the skills must pass them on to others. Rural people might be unemployed, especially women who are housewives, widowed and unmarried, but they are never without food. There is what is called group solidarity on vital issues, and this is central to the survival of African communities (Mbigi et al, 1995).

African communities survive through group care and not through individual self reliance. Village life is characterized by rituals and ceremonies to celebrate achievements and to share misfortunes. These rituals are also part of the communal sharing and recognition of the life experiences of others. Although there is tremendous participation and consultation among all members of the group, the position, authority and expertise of some pre-eminent individuals are respected. This brings elements of order and stability into the typical African tribal village (Cloete, 1992).

ILLUSTRATIONS FROM A SPECIFIC COMMUNITY

BASIC NEEDS - NATURAL AND COMMUNITY RESOURCES

Bolotwa at Idutywa has a large community which is not economically self sufficient. Most males are migrant labourers who provide at best an irregular source of income to the women who are left behind. 68% of all homesteads have at least one migrant worker. The women from other homesteads are pensioners. The little money they get has to be budgeted for clothing, foodstuffs and groceries, hut construction and basic agricultural products. Food has to be bought since the maize harvest is sometimes not sufficient because of drought.

Every household has a right to a garden. In 1993 only 10% of all households could harvest from either the garden or mealiefields because of drought. Despite drought these people had to survive. One must bear in mind that the mealie is the staple food of the region. From it, the local people make samp by stamping or crushing it roughly. They also make mealiemeal by grinding the mealies finely. With the mealiemeal they make a variety of foodstuffs like amarewu, stiff pap or porridge. If there is an
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individual without a mealiefield, the people in the community will offer her a part of their land so that she can also plough it so as to get mealies. They will even offer that particular person some help in working the land, and maybe plough for her. This help is often offered to unmarried women who do not own fields but have children to feed.

During the rainy season, to supplement their diet, women collect the leaves of certain wild plants which are edible and they use these as vegetables. They also gather plants which can be used to cure various ailments, including depression, headache, stomach cramps, muscular pains and menstrual cramps. Since women are also collectors of plant materials used in preparing herbal cures, their ethno-botanical knowledge extends to the types of macro- and micro-environments in which different plants thrive. Since the cost of western style health care is high it has been suggested that a large percentage of the rural population will continue to rely on the indigenous cures that are provided by women (Jonathan, 1989). This knowledge is passed down to the children.

Elderly women know exactly which grass should be used for making grass mats and brooms. They sell these grass mats and brooms to local shops and in the town. They also cut grass for roof thatching and sell it. By doing this they are supplementing the pension payment which they receive bimonthly.

The remittances the rural women get from their migrant husbands in the towns, are never enough. They have to survive in the period after the remittance has run out and before the next one arrives, when there is no money at all. During this period the family will depend on the neighbours or on the extended family system for survival. The common practice which keeps them going is exchange of products. This simply means that if one has got samp and she needs sugar, she simply takes samp to the person who has sugar and she gets sugar in exchange. An alternative to this exchange of products is that a person will simply go and ask for a particular commodity from a person who has got it, on the understanding that the second woman may then also come and ask for something she needs when she does not have it.

Young women are able to sell their labour to people who need some
help, people in employment like teachers and nurses, and this helps them to get some few cents. They may also give their labour for non-monetary gain and this is known as communal help. Unquestioning conformity is expected from everyone. Failure to comply with these survival techniques is met with ruthless measures.

The person who is in need of communal assistance announces that she needs help. If she wishes to build a hut maybe, she will have to make mud bricks, and so she calls for communal help. This help is commonly asked for and given for such activities as collecting firewood, harvesting, ploughing and plastering. In return the one receiving assistance has to cook for the people who are there to help her.

**ECONOMY MEASURES**

Women at the village of Bolotwa have to be very economical because the money they get from their husbands is not a regular income. Occasionally, the uncertainties of remitting the money, by post or a personal bearer, force the wife and mother to leave her children alone and go to the husband's workplace in a far-away town or city, to make sure of getting the money. If she decides that she needs more, she will remain there at her husband's workplace until she has collected enough.

When trying to be economical, rural women have to look for natural resources for making fire. They collect dry cow dung, the droppings from pigs, goats and sheep, weeds and maize cobs for making fire. They have to keep this collection for rainy days. To keep maize cobs away from being eaten by goats they have to plaster the heap of cobs with cowdung. Ash from firewood, cowdung and horse droppings are also used as manure in the vegetable garden.

Women are always expected to keep the home fires burning whilst the men are earning an income away from home. Rural women often have to walk some few kilometres to fetch water for cooking and bathing. They have to spend time gathering firewood for cooking and collecting cowdung for smearing the floors. Since the men are not staying with the women, during their absence the women go to the extent of building the huts themselves.
They make the bricks and then the builder will just build the house. The stones for the foundations are collected by the women, and after the hut has been built women have got to plaster it inside and outside and white-wash it. The women are aware of the exact season during which building is suitable. The safe time for building is usually the dry season between June and August.

Undoubtedly it is women who hold together and maintain the fabric of rural society, their diverse talents creating an environment in which life is possible, by making available what a human being needs basically: water, food and accommodation. Furthermore, rural women are essential elements in the structure of the country's economy, especially that of the large industrial centres. It is clear that if women were to leave their places in the home, the economy in its present capitalist configuration which depends on migrant labour sources, would collapse (Collins, 1990).

RURAL WOMEN AND DECISION-MAKING

Women in the rural areas have only limited decision-making powers, despite the fact that they are the ones who are always at home taking care of the homestead. There are however some instances where they are allowed to exercise their own judgement.

On children's education, 43% of women said that they decide about children's education on their own, 27% said the husband decides and 16% said that both husband and wife take the decisions. 14% of the women told us that male relatives like brothers-in-law make decisions about their children's education.

Regarding decisions about buying, selling or slaughtering of livestock, 24% of the women said they decide about selling of livestock. All the women decide on slaughtering chickens. 40% of women said the decisions on slaughtering, selling or buying of the livestock depends on the man. 16% mentioned that they take decision together. 14% indicated that male relatives decide about those issues.

Decisions about the cultivation of land were made by women in 41% of cases; in 24%, the decisions emanate from husbands. 16% of the women
said the decisions were taken jointly by husband and wife and 8% said it was the decision of female relatives like the mother-in-law.

As far as expenditure on food and fuel goes, 70% of the women decided about this issue on their own and only 6% said it was the husband’s decision. 8% indicated that both of them decide. 16% said the decision was made by relatives.

Decisions about the acquisition of land were made by 20% of the women on their own while 33% said it was the husband’s decision. 14% said it was the decision of both husband and wife; 20% said it was the decision of male relatives.

70% of the women decided by themselves about expenditure on household furniture; 8% of the women said husbands decide. 10% said both of them make the decisions in this area. 6% said it was male relatives and 6% mentioned that it was female relatives who made the decisions here.

In the matter of building rondavels or new houses, 40% of women decide for themselves; in 14% of cases it is the husband’s decision, in 26% both decide and in 20% of cases, male relatives choose what will be done.

As far as institutionalized decision-making structures in rural communities go, every rural area has got its chief or headman who controls the people in that area. If there is a need, he calls a meeting commonly known as ‘imbizo’. Historically these were never attended by women but in recent years women have been allowed to come and have a say in these imbizos. It has not been a very popular change. Men complain that women hardly talk in these meetings. Women feel that there is no point in having a place in these meetings because the men do not take any serious note of what they have to say. One woman told us that there are still some meetings where they are not called. Other women felt that they cannot speak freely or oppose what is said at an imbizo because sometimes it is said by their in-laws, and culturally the in-laws must not be opposed.

According to customary law in South Africa, women are legal minors and cannot own any property and this is what rural women believe still to be the situation. They are not aware of their new legal status that guarantees gender equality.
CONCLUSION

Women fulfil significant social tasks such as the transmission of abilities and skills necessary for survival in the rural environment, and the maintenance of the values and traditional beliefs of a society. But the work she does – gathering food, cleaning, cooking, sewing, etc. – has very little status and no pay in return (Epstein, 1971, cited in Jordan, 1994). It is really only men who earn money and enjoy the high status and economic power that goes with it. Women contribute a great deal indirectly to the family income; their hard work saves the family money, but it goes unnoticed and unrewarded (Arens, cited in Nelson, 1979).

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CHURCH AND
GENDER
In this section we have three essays which deal with religious constructions of gender and the stereotyping of gender roles. The study by Helen Cairns challenges the standard interpretation that in the Pauline writings confirmation can be found for the early Church’s emphasis on the woman’s submissive role. She shows that this view amounts to a misrepresentation of key texts and is based on a misunderstanding of the social and cultural context of the Hellenised cities of Asia Minor in which the early Christian communities were situated. It was in Asia Minor in the first century CE, in stark contrast to classical Athens and Rome, that Jewish and pagan women played a leading role in public life. Cairns points out that women had a leading role in the spread and survival of Christianity. The key text (1 Timothy 2:8-3:1a) in which Paul urges that he will allow no woman to instruct must be viewed within its immediate context. This must be sought in the strong female cultic presence at Ephesus in the form of the worship of Artemis. Cairns holds that women who joined the Christian Church in Ephesus introduced ideas, taken from the cult of Artemis, which were incompatible with the teachings of the Church. She goes on to trace the way in which female prominence in the early Christian communities in Asia was weakened and eventually completely eroded by patriarchal moves in the Church - ecclesiastical restructuring which edged women out, and the ascetic practices which identified women as evil temptresses.

Joan Millard’s essay on the life and achievements of Charlotte Manye Maxeke is a fascinating account of the struggle for educational and religious emancipation for blacks and black women in particular situated at the turn of the twentieth century. Maxeke’s life is much more than a story of racial and gender oppression; it is a good example of what can be achieved by one person of determination against all odds. Millard points out the relevant aspects of her career - her involvement in choir singing which enabled her to visit Britain and America, her studies in America, her leading role in religious affairs in South Africa. Maxeke always strived for the betterment of her people and of black women in particular, and can
be viewed as a role-model for women today. The last paper in this section, by Christina Landman, deals with the victimization of women by other women. Landman points to the millions of copies of manuals of personal piety written and bought by Afrikaner women. The portrayal of woman in these books is that a guilt-wracked creature whose only salvation lies in being submissive and subservient to God and her husband. Based on a series of vivid representative examples she shows how the reading of such piety manuals leads to the internalisation of a mind-set which is mainly conducive to perpetuating the patriarchal codes prevalent in the Afrikaner community. Landman subsequently places this phenomenon in a wider context of women using culture against women in Africa.

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