UJ Sociology, Anthropology & Development Studies

W E D N E S D A Y S E M I N A R

Hosted by the Department of Sociology and the
Department of Anthropology & Development Studies

UNIVERSITY OF JOHANNESBURG

Meeting no 28/2009

To be held at 15h30 on Wednesday, 7 October 2009,

in the Anthropology & Development Studies Seminar Room, DRing 506, Kingsway campus

‘Well in our culture a man does not like to be told by a woman to this and this and this … We were men nursing men’: Reflections on masculine care, professionalisation and colonial reinventions in South Africa

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'Well in our culture a man does not like to be told by a woman to this and this and this … We were men nursing men': Reflections on masculine care, professionalisation and colonial reinventions in South Africa.

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1. Introduction: reflecting on 'masculine care' and the 'new man'

The major significance of the opening statement is that black men had no issue with being nurses, or with performing feminised work. Rather, gender was important when it came to their resentment of female authority figures. As this statement was made half a century ago, there is a sense that South African men, and especially black men are changing in terms of how they view the world, and in terms of what they are increasingly willing to enact.

Various scholars have studied black masculinity, but have left me unsatisfied by the general aura of exceptionalism that is covertly present. Such exceptionalism takes various forms, such as the notion of the 'new black man' in South Africa (see *Men behaving differently* edited by Reid and Walker 2005), or the idea that men performing care is a new trend (see *Men as caregivers* edited by Kramer and Thompson 2002). In both instances I am uncomfortable.

Simply put, just because normative frameworks may exist (and have existed) to stereotype the work that men and women should perform does not imply that men have gone along with these sexist norms in their entirety. Male caregivers are not necessarily exceptions to a rule, especially when they uphold aspects of the rule that certain work is gendered. In the opening quote, nursing is not gendered by black men, but supervisory work is. The fact of the matter is, however, that it does not follow that the willingness to perform feminised work makes the work itself any less gendered.

While I suspect that there may be increasing attention paid to men who perform feminised forms of work, and while there are efforts being made to alter a sexist normative framework, it is clear to me that men are not suddenly conducting women's work in a more permissive environment. It is, essentially this view of historical and contemporary black men, involved care work that shapes the arguments presented in this paper.

I seek to move beyond finding evidence for my assertion that South African black men have performed feminised work, before such was necessitated by supposedly more malleable gender norms and the necessity of caring for PWAs, and, to a lesser extent, cancer patients. How do these men perceive the current normative framework regarding work and gender? Above all, what is the impact upon the ways in which these men shape, alter and live out their subjectivities?

Moreover, I also try to unpack the normative structures that, arguably, have allowed gendered work norms to become reinvented, and dare I suggest reinvigorated, in post-Apartheid South Africa. Ultimately I seek to link the past and present to:

- argue against the notion of the 'new [black] man' in South Africa, by finding evidence for black men engaged in feminised work;

- uncover the reasons and impacts of enacting masculine care work in the historical and contemporary periods;
- pay special attention to the normative framework at play.

In order to do so, I considered whether the lessons learnt regarding black masculine care is the past were a continuation of a stable trend in the present; or a reinvention of past relations that can be explained by what has gone before but did not lead to its happening in a teleological liner. My argument against the 'new man' is to take the form of historical continuity, rather than a colonial reinvention. I explore this in the following section. In so doing, the Foucauldian notion of 'biopower' will become an analytical lens when applied to both historical and contemporary findings[1]. On this basis I will conclude that an idealised form of black masculinity as linked to professional status is a critically important colonial reinvention.

2. Colonial continuities and reinventions

In *Colonial power and African illness* (1991: 8), Megan Vaughan argues that:

> in British colonial Africa, medicine and its associated disciplines played an important part in constructing 'the African' as an object of knowledge, and elaborated classification systems and practices which have to be seen as intrinsic to the operation of colonial power.

Nevertheless, she goes on to assert that it is not possible to apply Foucault's notions of power, particularly biopower, to a study of colonial Africa. Let us first consider what is meant by the term biopower, before proceeding with an analysis of Vaughan. In so doing, we shall move closer to an understanding of what I consider to be a colonial continuity as opposed to a colonial reinvention.

Foucault (1978: 143; 1997: 253) stated that:

> to speak of biopower is to designate what brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life
>
> [w]e are then, in a [bio]power that has taken control of both the body and life or that has, if you like, taken control of life in general – with the body as one pole and the population as the other.

From this it is clear that biopower operates within the stuff of life itself. It is 'an essentially modern form of power and its purpose is to exert a positive influence on life, to optimise and multiply life, by subjecting it to precise controls and comprehensive regulations' of both bodies and entire communities of people (Ojakangas 2005: 5). The opposite of biopower is sovereign power which refers to 'deduction' and the 'seizing of life itself' (Ojakangas 2005: 5-6).

If one cannot coerce and induce others to follow, as a sovereign might do, how does one exert biopower? It is 'exercised through the normalising biological, psychological and social technologies' that operate during the course of life (Ojakangas 2005: 6-7; Foucault 1978: 141). The most crucial of these technologies is the norm, which Foucault (1997: 253) defines as 'something that can be applied to both a body one wishes to discipline and a population one wishes to regularize'. The

[1] Archival material and outstanding secondary sources were consulted in order to construct the historical findings. For this paper, the contemporary findings were drawn from interviews conducted with 29 AIDS caregivers, and 18 cancer caregivers and nurses.

norms are no longer political, but rather scientific in nature, thus illustrating the link between power and knowledge (Ojakangas 2005: 17). In the era of biopower, a normalising society results (Foucault 1978: 144). Within this society, biopower is in action and:

> [i]t is no longer a matter of bringing death into play in the field of sovereignty, but of distributing the living in the domain of value and utility. Such a power has to qualify, measure, appraise, hierarchize, rather than display itself in its murderous splendor; it does not have to draw the line that separates the enemies of the sovereign from its obedient subjects, it effects distribution around the norm …. we should not be deceived by all the Constitutions framed throughout the world since the French Revolution, the Codes written and revised, a whole continual and clamorous legislative activity: these were the forms that made an essentially normalizing power acceptable.

For Foucault, pre-modern power was repressive, while modern power is productive power, and is embedded in commonplace and individual actions. Vaughan (1991: 8-10) states that colonial Africa is best characterised by repressive power, therefore productive power (which encompasses biopower) has no application. Repression is present in coloniser-colonised relations without question. However, repressive power is not uniform as 'colonial Africa' is not a single space in any symbolic sense. Mamdani (1996:7, 16-18) neatly distinguishes between citizens and subjects, who were not only defined as such by race, but also by space. Urban dwellers enjoyed better access to services in spite of racial classifications and restrictions. Therefore, we could argue that colonies in Africa operated on the basis of both repressive and productive power, albeit to varying degrees across time and space.

In addition to this, we must note Foucault's cognisance of the importance of racism. 'Racism is, in other words, the only way the sovereign power, the right to kill, can be maintained in bio-political societies …. It becomes a "demonic combination" of sovereign power and biopower, exercising sovereign means for bio-political ends' (Ojakangas 2005: 21-22). In less obscure terms, we could argue that colonial authorities regulated individuals and the populations on the basis of racial segregation. Biopower was based on notions of Victorian civility for whites, and a few black, urban dwellers who conformed to 'white' norms. Sovereign repressive power operated in order to keep the vast majority of black 'subjects' in check.

By ignoring the importance of racism, and the resultant 'demonic combination' of forms of power, Vaughan misses a vital opportunity to apply Foucauldian thought to her otherwise excellent work. In so doing, she creates a false separation between colonies and non-colonies. The implication is that biopower cannot exist in the colony, and that black subjects were not subject to the normalising society. This implies that biopower can only operate post-independence in African states. I seek to argue the converse in the normalising society we see in evidence in contemporary South Africa finds its roots in the colonial era and for biopower was in operation then, as it is now. It is not, however, a continuity for events did not flow smoothly from the past to the present. Rather, I shall argue for a colonial reinvention that finds itself in operation when we study black masculine caregivers in the past and present.

Aspects of the colonial normalising society are alive and well in South Africa, and indeed embedded within the aspirations of young black South Africans in the contemporary epoch. Vaughan would not agree for another of her problems with productive (bio)power is the fact that it can only be exercised upon persons who are aware of themselves both objectively and subjectively. In the

context of African colonialism, this should imply that colonial authorities 'operated through individual subjectivities', and this 'is open to question' according to Vaughan (1991: 11). I cannot disagree with the importance of questioning these sorts of assumptions. However, in so doing, we cannot dismiss the work of scholars such as Fanon, who makes a powerful argument for the ways in which African subjectivities are shaped by colonialism in *Black skin, White masks* (Fanon 1967: 223-232). As there is not a vast amount of historical data that was written by black Africans, I cannot simply hope to easily show that Vaughan might be wrong. Nevertheless, it shall become clear, as this paper progresses, that the presence of a particular colonial reinvention, possibly transmitted via socialisation, could support my belief in the subjective impact of colonialism upon the colonised that I have investigated.

Thus far, I have asserted my claims in support of a study of black, male caregivers through a Foucauldian lens. It is interesting to note that I made the linkage between Foucault's work, and my study, as there was common interest in certain key institutions. Foucault calls for a study of 'disciplinary institutions', which enact productive power (and biopower). These include the asylum, the clinic and the prison (Vaughan 1991: 8). Is it a matter of sheer coincidence that when seeking black South African men who are involved in care work, it was in the mental asylum, the hospital and the prison that these men were to be found? In other words, is it not possible that some of the black men, who had been denied access to education and have restricted occupational choices, as well as limited movement, should seek out employment in institutions that may contain untapped reservoirs of productive power? If we can imagine that these men sought out a space, that may yield some sort of biopower, then we can begin to see them as active agents, rather than passive colonised souls. I do not seek to abandon my argument that colonialism may have impacted their subjectivities. It is quite possible that these men were impacted, and were still able to act as agents in search of productive biopower. However, in seeking power, they could only have taken paths available within a repressive colonial regime

The goals that these men might have had are a clue to understanding an 'idealised' masculinity that was in operation. It is in examining this idealised masculinity, as linked to professional status, that we find evidence for a pathway to power, shaped by colonial influences upon their subjectivities. The evidence, as presented in the next section, is not absolute. It still provides us with room to suppose that it is possible to view colonial subjects as agents, and as socially constructed by the process of colonialism, on a more subjective level.

3. Leaps and bounds denied- struggle for more than a professional foothold: the tales of Ngoyi and Tsae

Seeking professional status in the world of South African nursing would prove difficult for black men and women alike. Since the 1870's 'white nurses were entrenched as the symbol of the [nursing] profession' (Deacon 1997: 81). Nevertheless, before attaining professional nursing status in the early 1930's, black men did find nursing work. This work was to be found in leper and mental hospitals such as those located on Robben Island (Deacon 1997: 82). The reason for this was that trained, white women did not choose this type of nursing work. As Deacon (1997: 98) explains:

> [it] was difficult to employ trained nurses at Robben Island, however. The growth in the number of hospitals (partially state-funded, partially public-funded) at the Cape during the latter half of the nineteenth century increased the demand for trained nurses on the

> mainland....The All Saint's Sisters were the only significant body of trained nurses to come to the Island; they arrived to look after the leper children in 1910. Even then, this only occurred after had been marginalized from hospital work on the mainland.... After the removal of most non-criminal white 'lunatic' patients during the course of the 1890's the Robben Island asylum had difficulty attracting mental nurses as well.

In addition to the near impossibility of obtaining qualified female staff, the work itself evolved into labour deemed more fit for men at the time. In other words, there was less nursing, and more custodial work available. As the gender barrier to this sort of work became weaker, the race barrier remained intact. Untrained white men were employed in larger numbers than black men. However, the fact that these men were white meant that they had to earn fairly high wages. This became 'a factor which contributed towards its [Robben Island leper hospital and lunatic asylum] closure in 1931' (Deacon 1997: 99). Therefore, black men could not ascend in terms of professionalisation, despite the fact that a small number may have found nursing assistant work for a short space of time.

The major event in this period occurred in 1931, when Ramasolo Paul Tsae became the first registered male nurse at Premier Mine (Burns 1998: 709; Mashaba 1995: 27). Interestingly, he was already a qualified school teacher prior to this. He may have felt that he could obtain greater autonomy by switching professions, for black teachers were often trained by missionaries and:

> [t]he missionaries looked to their African converts, male and female, to spread their evangelical message, and thus from the start trained African teachers....
>
> (Walker 1990: 15).

More than this, Ramasolo Paul Tsae would have taught in African schools and could not have escaped rural life if he had been content to remain a teacher. While he would not nurse white patients, he would enter a white urban space and may have had greater aspirations for the achievement of a better form of professional status.

Profits generated by the mining sector were critical to the development of the South African economy, especially to fund expansion into manufacturing. Low cost black labour was the ultimate source of the said profits. However, high worker mortality was a potentially limiting factor (Packard 1989: 1-389; Deacon 1997: 80). Mine workers complained about poor health care service provision. However, the tiny mine hospital staff compliments indubitably accounted for their dissatisfaction (Burns 1998: 695-717).

Though the mine workers may have found their health care services inadequate, rural blacks had a far greater lack of access to sound care. Thus, Tsae had to enter the urban mining arena if he and others like him, wished to work in a superior health care environment. The Loram Committee was convened, in 1931, to seek means of improving matters. A major recommendation was for the training of greater numbers of black medical personnel, yet this was rejected (Van Rensburg 2004: 1-45). However, what was rejected was the notion of a 'Government Native Medical Service' wherein the committee, egged on by black, American educated Dr. Xuma, noted:

> that it cannot recommend any course of training for Native medical practitioners which, as regards both training and examination, does not come up to the standard required of Europeans

(Shapiro 1987: 271).

The new debate continued to rage regarding the training of black medical workers. The contestation had to do with status. The first camp championed the training of black doctors, while still others wanted lower status 'medical aids' (Shapiro 1987: 234-235). When the state favoured the latter, application thereof faltered on the lack of structural support and resistance from black men (Shapiro 1987:254). It is important to note that this debate took place on a general societal level. In other words, what was being debated was the best means to structure the 'Native' health care system. As matters stood, even trained black doctors would only attend to black patients, and in rural black spaces. On the mines, worker mortality was a major issue and it was in the interests of mining capitalists to retain fairly skilled, but very cheap black workers.

Therefore, it is unsurprising that greater reforms took place on the mines. As we are now aware, the first registered black, male nurse Ramosolo Paul Tsae, obtained professional status when employed on Premier Mines in 1931 (Burns 1998: 709; Mashaba 1995: 27). Did such reforms indicate a shift in colonial attitudes towards black male nurses? While the political climate contained activists such as Loram and Xuma, no more than a tiny crack appeared in the normative society, propagated by mine barons who sought to maintain the Victorian that nursing was women's work. Ironically black women were responsible for this tiny crack. For a time, mine management exhibited considerable bias against the employment of men in feminised care occupations. However, the introduction of black, female nurses was fraught with disciplinary problems. These women made demands for greater respect and creature comforts such as laundry services.

These 'uppity' black women could not merely be replaced by more docile women for the disciplinary issues were not restricted to mine nurses. In a letter written by the Matron, a probationer, Nora Lillian Makxatho, was denigrated as follows:

> I [the Matron] took her [Makxatho] on your recommendation in spite of her age, but it seems she has been mistress of her own house too long to adapt herself to institution life and discipline. A fortnight ago she said "I won't" to a Sister, as she considered the work she was told to do was not her responsibility. On being reported to me she did the job, but I did not know till last night that she had disregarded my order that she should apologise to the Sister. I spoke to her, and told her the apology must be given … she has again disobeyed me[2]

Mine owners quickly came to the conclusion that black male nurses "did not pose quite the same contradiction to the dominant patriarchy" as male domestic workers had, as the men were deemed "more 'docile' and 'manageable' than their sisters" (Marks 2000:7).

Employed in greater numbers, black men would attain some degree of respectability and earnings. Never content to leave matters here, black men, especially those engaged in care, sought more. By seeking greater professional status, and achieving it in small, but significant numbers, black male nurses demonstrate a capacity for patriarchal encroachment upon the feminised space of 'care work'. This was certainly not a new trend, as men encroached upon midwifery both locally and abroad (Burns 1995: iii-iv; Deacon 1998: 271-292; Donnison 1988: 1-259)[3]. Black men soon demonstrated their strong *intent* to dominate the nursing profession. Moreover, in the mining

[2] Historical papers collection. University of the Witwatersrand. South African Institute of Race Relations Archives. AD 843/B41.411941-1944. Letter written by the Matron to Mrs E. Rheinalt Jones.

[3] See Deacon for the South African context, in terms of white patriarchal doctors displacing midwives; and Donnison for the European scenario. Burns usefully outlines how black women retained a fair amount of control over midwifery and received training until the 1950's when state intervention curtailed their acts.

context, the hospital was defined as a feminine enclave in a hyper-masculine world. This did not sit well with the agents characterised by idealised masculinity when choosing care work above more hazardous work in the bowels of the earth (Burns 1998:1). When questioned by Shula Marks (2000:12), male care workers did not feel put out by under-qualified white male superiors, yet resented female supervision:

> Well … in our culture a man does not like to be told by a woman to this and this and this …. We were men nursing men
>
> At the time we were just respecting the white colour. But now the black sisters do the same thing [as white men] – order the black men around

Paul Ngoyi was a key example of men who sought to gain a monopoly over Native health care. In a letter predating the reformist Gluckman Commission (1944), Ngoyi set out "his suggestions for improvements in the sphere of 'Non-European' health" (Burns 1998: 710-711). As Burns (1998: 712) remarks:

> Ngoyi suggested a series of measures to better staff the existing clinics throughout urban areas of South Africa …. Central to Ngoyi's schema was the suggestion that African male 'Medical Aids' and 'Orderlies' be drawn into the centre of all urban health care provisioning for 'Non-Europeans', not only in Johannesburg, but across the country …. Ngoyi saw an opportunity here for a cadre of men … finally to find a secure footing in the health structures of South Africa …. These men would work under white public health officials (virtually all white male physicians) but would supervise and regulate township clinics and therefore the labours of trained African women.

This is clear evidence for idealised patriarchal tendencies amongst black male care workers, for Paul Ngoyi was not unique in his aspirations (Burns 1998: 710-715). Nevertheless, reformist thinking was once more relegated from mainstream health policy as recommendations from both Ngoyi and the Gluckman Commission fell upon deaf ears. Structurally, the nursing profession remained a female enclave. Yet, men such as Ngoyi sought power and had attempted to influence a racist and sexist normative society.

Did these patriarchal encroachment tendencies emerge in efforts to resist white colonial and women? Or, were they the product of a patriarchal rural legacy? Morrell (1998:628) claims:

> [h]ere we are in a grey area between black [rural] and African [newly urbanised] masculinities, where links with the rural area and its mark on masculinity are declining, no longer dominant, but neither absent.

Morrell's sentiments are endorsed by Father Trevor Huddleston (1956:94):

> It is often said, and with some truth, that the African in the towns has lost all the old tribal sanctions and nothing has been put in their place. It is also true, however, that some of the old customs, transplanted from country to town, have an equally disastrous effect.

What is clear is that the patriarchal tendencies demonstrated by black male caregivers, like Paul Ngoyi, could have emerged from the legacy of rural patriarchs, and the patriarchies, that had gone before them (Bozzoli 1983: 139-171). Hodgson (2000: 1-28) would dispute this in terms of her evidence against the 'myth of the patriarchal pastoralist'. She argues that thinkers have found it easier to subordinate rural women, but that rural men did not unequivocally dominate rural society.

Epprecht (2000: 72-73) lends support to this argument. He found that rural Lesotho women often turned to colonial magistrates in order to circumvent and overturn the decisions made by black patriarchs. For example, as early as the late nineteenth century, a young woman named Ramolawa:

> ...obtained a *de facto* post-mortem divorce from her violent husband against her father's will. In this case the father wanted her children as custom warranted. The court ruled, however, that he had forfeited any customary rights because his behaviour invalidated his moral authority. Specifically, when the husband was still alive and mercilessly beating Ramolawa, he (the father) had repeatedly 'thrashed' her to force her return from *ho ngala* (so that he could keep the *bohali* that had been paid for her). In granting her a post-mortem divorce, the court protected the widow Ramolawa from impoverishment by an obviously mercenary father.
>
> (Epprecht 2000:72).

My analysis of domestic work in Natal (Dworzanowski-Venter, forthcoming) shows us that there were contestations between younger and older black men in rural areas. On the mines, we also know that age hierarchies continued to exist. However, one cannot ignore the fact that "rural patriarchs continued to display much the same attitude as many white male medical officials: men were no good for nursing, which was a peculiarly womanly task" (Burns 1998: 715).

How does one reconcile the views of Hodgson (2000: 1-28) and Epprecht with that of Burns (1998: 715)? The only conclusion one can draw is that the rural context is a contested space. Rural patriarchs did exist and exhibit sexist attitudes. Simultaneously, women held some degree of power and control over their lives. The discussion, within this period, has also shown that gender-based contestation occurred within the urbanised nursing context, as black men sought greater presence and power. From a deconstructionist stance, it is important to understand that stereotypically male and female, or rural and urban social spaces have no *absolute* basis in reality. As Kerber (1988: 39) puts it:

> One day we will understand the idea of separate spheres as primarily a trope, employed by people in the past to characterize power relations for which they had no other words and that they could not acknowledge because they could not name, and by historians in our own times as they groped for a device that might dispel the confusion of anecdote and impose narrative and analytical order on the anarchy of inherited evidence, the better to comprehend the world in which we live.

This may explain why subordinated, young, black men were 'quasi-subordinates' at best. They evolved an idealised masculinity to counter white power, female power and the power of their elder patriarchs. Such an analysis is often ignored when gender dynamics are excluded in favour political and economic factors identified by thinkers embedded in euro-centric paradigms. Black men, such an Ngoyi, were attempting to challenge both white, black patriarchal and matriarchal power within the contested terrain of nursing care. The fact that they were rebuffed does not mean that we may dismiss the clues that this leaves regarding their 'idealised' masculine identity.

Ngoyi may have been rebuffed, but this did not stop others from seeking to make professional gains on the mines. A key event in this period occurred in 1959, when we encounter Ramasolo Paul Tsae yet again. He, and four other Native nursing orderlies, petitioned the general manager at the

Transvaal and Orange Free State Chamber of Mines. Their request was to establish a Mines African Nursing Orderlies Association[4] and was put as follows:

> At a meeting held on the 15th February, 1959, it was resolved that an Association for the Nursing Orderlies employed on the mines affiliated to the Transvaal and Orange Free State Chamber of Mines, be established. And as the establishment of the Association contemplated would require the Organising Committee to convene a series of meetings on the mine properties from time to time, it was further resolved that a written request be submitted to you.
>
> The request, which we hope will receive favourable consideration, is that the Mines which are members of the Chamber be requested through your department to make arrangements and facilities for meetings preferably in the Hospitals, and also to provide food for the delegates if the Management of the Mines on which such a meeting is to be held have received a written application from the Organising Committee for the meeting to be held on their property.

The request was signed by the organising committee, namely:

> Paul Y. Mlamela (Durban Roodepoort Deep)
>
> Paul T. Ramasolo[5] (West Rand Cons.)
>
> Sam Mafole (Blyvooruitzicht)
>
> Charlton Piliso (Rand Leases)
>
> Isaac Nxumalo (E.R.P.M).

In each part of the above letter, there are important insights to be gained. In the first paragraph, it is important to note that these men were not asking for permission to form an association per se. Rather, they were asking to space and time to be allocated to the functioning of the proposed association. The second paragraph is related as they ask for room to meet in the mine hospitals. It is obvious that these men did not feel entitled to make use of this space. The third part of the letter shows us that the organising committee stretched across several Witwatersrand mines and this implies a fairly broad network of men interested in taking greater steps towards professionalisation while seeking to improve and entrench their position on the mines. The notion of collectivity was extended by these men on the 7th of May in 1959.

In a general information circular[6], dated 7 May 1959, the organising committee went on to state:

> Our immediate concern is that the vocation of each one of us can only become effective within collective planning .... Because of the nature of training the Orderley receives viz. to care for the Sick and Injured Mine Native Workers, the Association can only be composed of Africans confined to a particular industry. In this case the Mining Industry.

[4] WNLA archive depot, TEBA archives, 10D 'Examination of mine natives hospital orderlies rates of pay'. University of Johannesburg. Letter written by the organising committee to the General Manager on 7 April 1959.
[5] I have made the assumption that Paul T Ramasolo is the same individual as Ramosolo Paul Tsae. It is likely to be a cultural convention that accounts for the differences in the presentation of his name. I find it impossible to believe that it cannot be the same registered male nurse that is cited in secondary sources. There were a relatively small number of male nurses, and therefore it is highly likely that this is the same person.
[6] WNLA archive depot, TEBA archives, 10D 'Examination of mine natives hospital orderlies rates of pay'. University of Johannesburg. General information circular written by the organising committee on 7 May 1959.

> .... Of course, it will be absurd to think of privileges and rights before the Association contemplated is formed.
>
> ....While awaiting replies [to letters such as the one already cited requesting permission to function on the mines[7]] the Committee suggests:-
>
> (1) That each Hospital organises itself into a unit complete with Office bearers,
>
> (2) That each unit sends to the Organising Committee a list of names of both the Qualified and Unqualified Nursing Orderlies both "A" and "B" grades. Female nurses should be included unless State Registered.
>
> (3) That each unit sends any suggestions regarding the Proposed Association.
>
> (4) That where the Management of the Mine are agreeable the unit should organise a meeting and if desirable arrange for the Committee to attend.

The attempt to obtain greater status and rights is clear in the above extract. As these men were clearly dissatisfied with the training that they had received, they sought to define themselves within their race and occupational setting. By seeing their Association as an 'Africans only' organisation, race became neutralised and they found ways to exclude state registered females. This, in some ways, extends and entrenches the position taken by Paul Ngoyi in the previous period.

To the best of my knowledge the Native Orderlies Association was never given official permission to form. In fact, permission was denied for meetings to be held at Durban Deep[8], and the Gold Producer's Committee did not even deign to place this matter on their meeting agenda[9]. While this was unfortunate, it does not obscure the main point that I seek to make which is that black masculine care was performed by men who sought to leverage their position in a feminised work space. Therefore, they made an effort to move beyond the racist normative structure by subverting sexist assumptions. Despite the repressive forces (as linked to race) and the more insidious sexism inherent in the productive, hierarchical, biopower, these men demonstrated intent to obtain professional status. 'It is not that life has been totally integrated into techniques that govern and administer it; it constantly escapes them' (Foucault 1978: 143). Successful or note, Ngoyi and Tsae demonstrated an awareness of self that escaped the limitations placed upon them by the colonial bio-polity.

As the presentation of contemporary findings will suggest, this process is not unfamiliar, albeit nuanced, amongst present day male caregivers. The gendered normative structure remains fairly intact. However, the normative coping mechanism (i.e. seeking a professional and idealised

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[7] These letters were written to the Chamber of Mines, managers of individual mines as well as to the Secretary of the Mines Medical Officers Association. The latter was contacted to 'give moral support to the proposal'. WNLA archive depot, TEBA archives, 10D 'Examination of mine natives hospital orderlies rates of pay'. University of Johannesburg. General information circular written by the organising committee on 7 May 1959.

[8]WNLA archive depot, TEBA archives, 10D 'Examination of mine natives hospital orderlies rates of pay'. University of Johannesburg.Letter written to Paul. Y. Mlamla from the Chief Medical officer at WNLA Ltd, dated 17 July 1959.

[9] WNLA archive depot, TEBA archives, 10D 'Examination of mine natives hospital orderlies rates of pay'. University of Johannesburg. Circular no.34/59. Transvaal and Orange Free State Chamber of Mines Gold Producer's Committee. Minutes of meeting of the sub-committee of group medical officers, held in the Chamber of Mines building on Friday 31st July, 1959, at 10am.

masculinity) acts to compel contemporary caregivers from the care work environment, or extant professional status insulates our men. A detailed discussion now follows.

4. Contemporary masculine care: a flight to the space of 'true' professions

Caregivers involved in community-based and hospital care for AIDS and cancer patients presented a discourse that contained echoes of a gendered normative structure, and the importance of professional status. Let us begin with due consideration of the former.

Is care work embedded within a normative structure that defines it as feminised? If so, what is masculine work? The simple answer is that interview respondents repeatedly alluded to the gendering of work. For example, Irene (rural caregiver) suggests that:

> *women are socially defined as caregivers and secondly this is the rural part of Venda that is composed mainly of poor people. Since most of us do not have a high educational status when they recruited volunteers more black women went into the labour force …. As Venda women, our parents restricted us to attend schools, only boys could go to school. If you get an opportunity as a female to go to school you should consider yourself lucky. However our parents chose occupations like nursing and teaching for us. Due to our gender and race we did not have any say in the matter*

The blurring of 'traditional' African perceptions and 'Western' notions of success hint at a colonial reinvention when expressed by Sylvia (rural caregiver):

> *White people, especially males go for occupations like engineering, law, medicine, accounting, etc. In the modern society women have become masculine and they have freedom of choice…. As for blacks from the rural areas gender does determine occupational status because people are still old fashioned. Culture is respected more than anything, as there are roles assigned for women, such as unpaid domestic labour and caregiving (Sylvia)*

Makungo (rural caregiver) takes this further by stating:

> *If I was born male I would have been an engineer, doctor, lawyer, or even maybe a lecturer. The fact that I am a woman justifies the 'myth' that women are socially defined caregivers (Makungo)*

What we have here is a situation in which two black women, working virtually side by side as caregivers in rural South Africa, define certain jobs as gendered and as racialised. There is a sense that 'white males' opt for professional jobs and that these are sought after as they are well paid. There is also a suggestion that black men should seek similar occupations and earnings. It is, as if, there is an aspirant black masculinity that emerges here. For example, Elizabeth suggests that other men view male carers:

> *as lazy bugs who are lazy to work and are not men enough to take other jobs such as engineering.*

Interestingly, the men involved in cancer care found themselves located within a similarly gendered normative structure. However, professional nursing status did act as a buffer. For instance, Cebo (professional oncology nurse) contends:

> *Not **all men** want to do this job. They want to be lawyers and managers of big companies. Power. They want power…[for men] money equals power. If you have money you have the power. In this profession you don't get a lot of power …ag, I mean money. You get enough to support you and your family. And to live a … and to live a respectable life. But most men want the big houses and the fancy cars …. Women are natural caregivers ….Women like to do this because of their natural abilities. But men … Eish it can discourage them from doing this job (my emphasis added)…. But I come from a … what do you it … a matriarch family. I did not grow up with a dad. Or at least he did not live with us, and I had lots of sisters. So for us, care work is not a 'gay job'. It's a respectable job. I am helping people (my emphasis added)*

Most men and women sampled reported that male caregivers were stigmatised by men and women in broader society, most especially in the rural context. This stigma took several forms. The men were dubbed too "dumb" to attain proper qualifications, and other forms of work. Some men complained that women refused to date them because they were engaged in poorly paid, feminised work and this was a blow to their masculinity. Further slurs on their masculinity came in the form of being called 'homosexuals' and 'softies'. The car work itself was undervalued as male carers were called 'lazy bugs' who did not seek "proper" employment and they were called 'fools' by men and women alike. As two rural women put it:

> *most people thought those men* [fellow male caregiver volunteers that used to work with her] *were homosexuals and were criticised by other men for performing female labour without getting paid (Tambani)*

> *some [men] do and some do not qualify [to act as caregivers]. Those who do qualify are more urbanised and believe in gender equality. Some people would even classify those who qualify as 'homosexuals'. Or let me put it in a nice way, they would be suffering from a **'gender confusion sickness'** (my emphasis added) (Joyce).*

The general societal gender essentialism that lies at the base of these stigma-oriented attitudes trickled into the minds of some female caregivers. For instance, a rural female respondent declared that there is '*a cultural belief that women are socially defined as caregivers'* and her colleague allowed this view to colour her perceptions. She felt that women are naturally more suitable caregivers:

> *women are more determined and self-disciplined than men. Men, on the other hand are aggressive and harsh; and prefer jobs that require technical skills. And, most importantly, women hope that someday their jobs will be recognised and recommended (Rendani)*

Rendani feels that women are suited to certain forms of work and that this work is under recognised. This line of thinking was echoed and taken a step further by Tambani, who works in another part of Limpopo:

> *Women are more emotional. Men show the emotions of anger, outburst, fits of rage etc. whereas women cry and show compassion. Therefore, allow me to justify that caregiving is a job for females*

What Tambani suggests is of paramount importance. The idea that women are 'more emotional' actually refers to two underlying assumptions. The first of these is that women are more likely to express more non-aggressive emotions such as compassion. The second point is that men

experience 'out bursts' and 'fits'. The implication is that men cannot control their emotions and, thus, men cannot perform emotional labour. One this basis, she argues that 'caregiving is a job for females', thereby showing that emotional labour (Hochschild 1979 & 1983) is the most important, and gendered, part of care.

From these two women's responses, a dual impression is created. Care work is, essentially, emotional labour, and this can only be carried out by women. Moreover, there is a need to recognise this form of work as only women can do it. Should this work be recognised and receive higher status in society, this may enhance female empowerment, at least in the eyes of these respondents. What this tells us is that there is an interesting understanding of gender equality that operates here. There is a sense that the sexes must be 'separate but equal'. In other words, there are gendered forms of work and this is in order for as long as all types of work are deemed equal. When exploring this further, Elizabeth asserts:

> *Well nowadays we have gender equality at the workplace. Who knows maybe in the near future South Africa will be ruled by women.*

Xolani, a peri-urban male, puts the notion of empowerment via role reversal more strongly:

> *I think Mandela and his government have brought changes. With Mbeki most things favour women and soon women will be sitting on couches with a beer watching soccer and men will be in the kitchen cooking and doing laundry.*

Both of these quotes suggest that there is a strong tendency to maintain gender binaries, by men and women, and that female empowerment will come about by role reversal. This is problematic as the notion of gender-blind non-essentialism is somewhat present, but is overwhelmed by the need to maintain gender binaries. In seeking to sum up the situation that these men find themselves in, Lungisile, puts it best:

> *AIDS care work is something that makes a man cry. One cannot be a caregiver without being emotional. Trust me at first I thought I was just doing it because I was bored but now I have realized that I have an emotional attachment with my patients. One has to care, love, listen and understand the patients. It's more like the doctor and patient relationship or mother and child. Now I feel sad and feel like crying most of the time but in my culture a man is not supposed to cry… I do talk to my male friends but sometimes they discourage me because they always remind me that I'm doing women's job. I have also spent time with the psychologist who has helped me a lot. Now I talk to other caregivers and they show me the light.*

This is a highly problematic situation. We have a group of caregivers that perform crucial work together and form some sense of closeness and emotional support. However, gender essentialist notions persist and this hampers the formation of true caregiver-caregiver solidarity.

The acquisition of professional status seems to partially insulate our male oncology nurses from sexism and gender-based criticisms. As Cebo suggests:

> *It's because for blacks that it is a good, respected…respectable job to have that I became a nurse … but for me growing up in the townships it's always better to become a registered nurse. Doing a job that will make your family proud …. I am now respected in my community. I don't know if a white nurse will get the same respect. No! No. I think they will. But in the black community it's different. I made something of myself and everyone is proud*

> *of me …. I think there are a lot of blacks that want to do this job. You see, to us … to us it is a very high status job. To do this job is celebrated in our community*

From the above quote, it seems clear that being a professional nurse allows one to acquire status in one's community. Yet, in Cebo's case, his motivations are not entirely linked to community-based status. I would like to assert that his sense of community pride in his achievements may have still more to do with his personal, familial relations. When asked about his motivation to care more directly, Cebo said:

> *I had to make a choice, right. I could either become like my cousins and stay in the townships and rob and kill for money. I didn't want that. My mother didn't want that for me. So when the opportunity presented itself for me to get an education and study I did it ….And became something that my mother can be proud of …. She's very proud. Very proud. To this day she brags about me being a nurse and* ***working in a fancy hospital*** *(my emphasis added).*

However, he does acknowledge that he is different to other black men, and this underlines my belief that his family pride and support insulate him from a pervasive gender based stigma and essentialism that is still present in his community. If a caregiver is not enabled to retain a sense of his idealised masculinity by virtue of his professional status in this way, what is he likely to do? The high turnover of male caregivers reported across all AIDS care locales in my study is a possible answer. Informally skilled AIDS caregivers, employed by CBO's, often make use of this work as a temporary measure, an income 'filler' until they can obtain 'real' jobs, for 'real' men. For the majority of the men in this study, care work is defined as temporary, community work. In other words, the work that they do is not deemed real employment. As Thabo claims:

> *yeah and then like I think, according to my mind I've told myself that if I go for another job somewhere, I won't* [be] *caring for the sick …. like here there are so many ladies who hold high positions and then around the township still, especially on this AIDS programmes, they are all run by women. Men are just scapegoats, yeah…*

The gender role reversal and 'care as feminised space' perception runs strongly within his assertion. He does not seek to remain in a female dominated environment. This is a contextual issue, however, as Thabo does not deem women more effective carers: *I think it is easier to be both a male and a female caregiver.*

His need to leave this type of work was echoed by the majority of peri-urban, male, caregivers interviewed. This is fascinating as these peri-urban men work in an exclusively male care organisation. It would be appear to be very strategic as these men have formed a masculine care cadre. In spite of the exclusively masculine environment, where we find 'men nursing men', these men rely on the first strategy, that of defining their care work as feminised and, therefore, a temporary measure to earn much needed wages. All of these men report high levels of gender-based stigma and they all seek to escape to undertake more manly occupations.

As Lungisile puts it:

> *But if I could get another job I'd definitely take it because what I'm doing is suitable for women*

Despite the fact that these men are in a unique position to challenge gender norms, they cling to an idealised masculinity, epitomised by traditionally masculine occupations with high earnings. This idealised masculinity has its roots in the biopower (and the gendered normative structure) that was enacted by colonial mining authorities. The 'traditionally masculine' occupations are occupations for white men, and black men would seek to ascend in similar ways. This notwithstanding, the realisation that this facility is an opportunity to challenge gender-based stigma is not lost on these men, as Bongani clearly states:

> *I guess they wanted to do something different altogether. You know they say men are not good with feminine related jobs, well here we have proved people wrong.*

Yet, in spite of major financial constraints, this caregiver has a very clear exit strategy as he has saved funds and wishes to study pharmacy. While keen to volunteer once he takes on full-time study, he sees this as civic duty.

In discussing these findings, it becomes clear that none of these men define care work as a real occupation and perform it so as to earn a little money in a strapped environment. They clearly seek to move on to more financially rewarding, and conventionally masculine work at the soonest opportunity.

Nevertheless, there is reason to believe that not all of the men are in the thrall of idealised masculine occupations. A township care worker, Mxolisi, demonstrated the inclination to remain a caregiver and reported comparatively neutral gender perceptions of men as carers. However, each man had his own reasons. The first man said '*look at me now, I am employed as a trained caregiver'.* He deems himself skilled and affirms a worker identity as a legitimate 'employee'. Added to this is a second coping strategy:

> *No! [it is not easier for women to be caregivers]. Some women are victims of rape especially here at Alexandra late in the evenings …. The problem with me is that I have so many girlfriends but I still preach the gospel of HIV/AIDS and risky behaviours, what kind of monster am I hey?*

Mxolisi clearly does not experience the gender-based stigma reported by some of his colleagues. He is able to date many women and assert his masculine virility via promiscuous behaviour. Mxolisi also usefully points to pertinent gender-related issues such as violence against women. In both instances, our male caregiver is able to assert a sense of masculinity that has something to do with occupational status and earnings, and also is related to non-economic motives.

You will recall that I made mention of an idealised masculinity in Chapter Two (Morrell 2006: 16). The respondents in this study do recognise political change on the gender front. However, this does not stop our men from desiring an idealised masculinity in one form or another. Ratele sheds light on what black men, in general, may have 'idealised' as masculine. Men seeking ideal forms of masculine domination link this state to 'assertive heterosexuality', 'political authority', 'support for male promiscuity' and 'control of economic decisions within (and outside) the home' (Ratele, 2006:51). If we couple this with what we know these men may gain from being recognised as professionals, which includes 'autonomy', and a 'monopoly over a defined sphere of work' we begin

to gain greater insight into what our men idealise as masculine work (Last and Chavunduka 1986: 6).

The men who see care work as temporary are those that want to 'assert' their 'heterosexuality' by taking on stereotypically male work so that they can best 'control the economic decisions' that are made. These men have a different 'idealised masculinity' to that of the men who seek to remain in the care work arena. The latter either define care work as employment worth taking on, or, retain an 'assertive heterosexuality' via promiscuity. There are costs and benefits attached to each of these strategies and these will now be explored.

While the perception abounds that women are more natural care workers, and are therefore socially defined caregivers, little can be accomplished. While gender-based stigma exists, care work will remain socially constructed as feminised. This will continue to force men out of caregiving as is evidence by the first strategy employed by the men in this study. Should we seek to evolve 'males-only' care enclaves, this reeks of the same, albeit inverted, gender-based stigma that forces men out of feminised work. The retention of masculinity via promiscuity is another flawed strategy. As it goes against the 'safe sex' gospel that is preached by most caregivers, it is likely to create dissonance and unhappiness in the longer-term.

By far the healthiest, and most useful, strategy was adopted by the caregiver, Mxolisi, who defined himself as a 'worker'. While it is a pity that he clings to promiscuity as a stereotypical marker of idealised masculinity, he is still able to positively reinforce his sense of masculine worth by valuing the work that he performs. This is critically important as the evolution of a worker identity is the first step towards evolving a collective of workers. Most of the caregivers in this study evidenced the belief that community-based AIDS care is unskilled work, on the basis of their lack of recognition that emotional labour is indicative of skills. This, coupled with the fact that they work without protection in the informal sector, yet are subjected to rules and fairly controlling coordinators, who can dismiss them, indicates a problematic state of affairs. If the men involved in care do not recognise themselves as workers, they cannot contribute to the much needed worker activism required to provide greater protection and more autonomy to caregivers. Or put differently, there is clearly room for a new professional category within health care – namely, the community based health care worker. This is currently an analytical category but it is yet to obtain recognition as a 'profession' in the more formal sense.

In clinging to an idealised masculinity, the men who seek to exit are not asserting a caregiver as worker identity. At the heart of this neglect is a set of gender essentialisms that underpin gender-based stigma. Should these men begin to perceive themselves as workers, and remain in the community-care sector, they will not only mobilise for greater rights as workers, but may help to undo a very persistent gender binary.

The findings presented in this paper have shown us that black men are aware of the dire need for community-based caregiving. They have decided to act and to accept this work as a largely temporary measure. In this way, they maintain an idealised masculine identity, in spite of conducting work that remains highly feminised. What this amounts to is a suspended masculine subjectivity that is kept alive by means of an idealised masculinity. Our female caregivers define AIDS care as their own social space, and do so by reliance upon persistent gender essentialist notions. While they have no personal problems with male caregivers, they have good reason to hope that gender essentialism and stigma will push men from the world of AIDS care. As rural

caregiver Portia explains: *more women are going into the unpaid labour force … something that poses a challenge to men*. What is implied here is that despite the informal nature of their work, women gain skills and a pathway to long term future employment in a space that does not allow men to encroach. In this way, women will gain greater independence and financial resources. How does this pathway operate? Rural hospital caregiver Sara's situation is illustrative of an apprenticeship of sorts:

> *I would not really say money is a motivating factor because I volunteered for a period of five years before **being employed** as a trained caregiver. I am also grateful that at least now I can take care and provide for my family*

The same sorts of 'apprenticeships' are available to volunteers attached to urban hospitals and NGOs. Yet, men are less likely to use this pathway to full-time employment due to pervasive sexist beliefs about feminised care work. Lungisile (black, male peri-urban caregiver) stated:

> *Well I couldn't just sit and do nothing. As you can see I only have standard six and couldn't get into formal employment, so I volunteered as a caregiver. At least now they are paying us, which is something. But if I could get another job I'd definitely take it because what I'm doing is suitable for women.*

5. Conclusions and recommendations

On the basis of these findings, I have argued that an idealised masculinity has become attached to professional status for black masculine caregivers in the historical and contemporary eras. There is a pervasive sense that black men must succeed in 'white' spaces (i.e. professional occupations). This is a reinvention, and not a continuity, for in the past black men were willing to perform feminised work if it meant financial independence. In the present, our non-professional caregivers found themselves involved in 'women's work' as a similarly last resort, yet many of them seek to escape it. Both sets of men have decided what it takes to be masculine, and financial independence is common to both groups, and this is not necessarily a colonial reinvention.

Rather, the colonial reinvention comes into play when we note the operation of idealised masculinity as linked to professional status. In exercising power on the mines, colonial authorities relied on racist (repressive) sovereign power, as well as biopower that was embedded within a sexist normative structure. Unskilled black men were a cheap source of labour, with no prospects for promotion. Black men willing to perform skilled surface work, such as nursing, were of use to mine owners who found them more docile than black women at certain points in time. However, I contend that colonial biopower was strongly influenced by gendered divisions of labour. When harnessed, these sexist notions could be used to prevent black male orderlies and male nurses from ascending in a professional hierarchy. The sexist norms have been allowed to persist – but have now reinvented themselves. Therefore, our contemporary black men still idealise professional status, and tie this to their masculinity. However, only a limited number of them choose to become professional care workers (and usually if this is the only avenue open to them), while the vast majority want to work in stereotypically masculine professions, where whites have set the gendered, normative stereotype. It is unsurprising, then, that informally qualified male caregivers seek to exit, rather than to mobilise as workers.

What of our historical actors? Men such as Paul Ngoyi and Ramasolo Paul Tsae were indubitably far more mobilisationist. Ngoyi agitated for reforms in Native health care that would place black men firmly in charge, and no longer subservient to black women. Clearly learning from the outright rejection of the reforms proposed by Ngoyi, Tsae attempted to mobilise on a smaller scale by requesting the formation of a Native Orderlies Association on the mines. What this tells us is that professional status was sought, and despite both incidents becoming fruitless struggles, we begin to understand that professional status matters to black men, both past and present. Moreover, this hankering after professional status is linked to an 'idealised' sense of masculinity. Black men, trapped in low status work on the mines, idealised professional work as it would give them a higher symbolic status (and this could well be linked to higher wages). This allowed them to cope with gender-based stigma.

Echoes of this are found in the responses of our cancer nurses. They have attained professional status in health care – and having done so, they use professional status to idealise, and insulate, their masculinity from sexist attacks. The common factor here is that all of these men were involved in formal health care, and most were nurses. In other words, they operate within the framework of an existing profession. None of our informal caregiving men are deemed true health care professionals. Mine hospitals and oncology wards[10] are their care environment. The nature of AIDS is such that formal health care in South Africa cannot cope, and the burden of care has fallen to communities. The men in this study perform informal sector care work as a temporary measure, and cling to the aspiration of professional work. This allows them to reach for the 'ideal' of professional status at some future date.

To my mind, our AIDS caregivers also have an expert knowledge – at least in terms of their ability to conduct emotional labour when caring for PWAs. Our AIDS caregivers across multiple spaces, be they urban or rural, reported performing startlingly similar emotional labour techniques. What is clear is that the nature of the care and the site of care have an impact upon perceptions of professionalisation. Nursing in a hospital, and performing care with a greater biomedical component implies greater professionalisation and status accrued by care worker. Our AIDS caregivers did not recognise their expertise in terms of AIDS care – rather, our men saw it as temporary, and all of these men had no perception of a professional status that could insulate them from the impact of sexist slurs directed at them for conducting feminised work.

The argument that is beginning to emerge here is that AIDS care workers, in the informal sector, who have little/no formal education are potential professionals. The women engaged in AIDS care seem to be aware of potential professionalism – though this is not an accurate assumption as they want to enter an existing professions (i.e. nursing). However, the men interviewed have reported no cognisance of their potentially professional status in the care sector. At best, these men regarded themselves as employees, or 'workers', but this did not extend into mobilisationist efforts to organise, campaign against gender essentialist stigma and to remain involved in AIDS care. One male caregiver, located at a 'males only' facility did mention that they were potentially challenging established gender norms by performing care for men, and by men. However, this is a simple inversion of gender essentialist notions and does little to do away with sexism. It is reminiscent of the strategy employed by men like Ngyoi and Tsae. Their mobilisationist efforts should be

[10] While cancer care is also community-based, in terms of hospice work, no men were to be found when interviewing for my study. There were, however, men to be found in oncology wards.

commended, but they did not seek to undo white hegemonic definitions of professional success. Rather, they sought to increase their professional status, in white terms, and to subvert (but not undo) gender essentialist notions of care as gendered.

What I seek to argue is that informal sector care work is a potential profession. In so doing, it proves instructive to consider the notion of the 'guild', as professions emerged from guilds in the European context, and there may be lessons here for my study (Last and Chavunduka 1986: 7). Broadly speaking, a guild is an association of workers that have a specific ability, or skill. Guilds tend to form some sort of civic authority over a particular area of expertise and can mediate relations between the State and the guild members (Reid 1974: 37; De Munck, Lourens and Lucassen 2006: 67). Historical evidence suggests that Zulu washermen established a guild, the *Amawasha*. This guild was in operation, in Natal, from 1850-1910 (Atkins 1986: 41). This guild did tend to operate in much the same way as classical European craft guilds while simultaneously managing 'to incorporate vestiges of even earlier trade groups of *izinyanga* (skilled craftsmen) who specialized in hide or skin dressing' (Atkins 1986: 41). As Atkins (1986: 43) discovered:

> [w]ithin the guild, working conditions were regulated, members were disciplined, and work standards were upgraded by membership.

The *Amawasha* guild was structured along age lines, for 'age or senior rank [within the rural community of origin] was a criterion for entry' (Atkins 1986: 49).

In some ways, our informal caregivers are guildsmen and women. They are informally recruited, and perform work in order to meet an important social need, and to satisfy their personal need to act in a productive manner, despite their (usually) unemployed status. Their work does not have the direct economic value attached to craft work, but if my findings reflect reality, then they are skilled emotional labourers. They are a germinating guild and a potential profession if we take all of the above into consideration.

The primary policy recommendation that has resulted from this study is that informal sector caregivers be strongly encouraged to partially formalise their potential professional status in the form of a caregiving guild. By providing them with more formal education, they could expand their practical wisdom. In so doing, they may come to realise that they are part of a potential profession, and may mobilise to form a guild. They may accrue three major benefits in so doing. Firstly, they will gain greater status. Secondly, they may become enabled to negotiate for stipends, as attached to the apprenticeship period – thereby ending the exploitation of caregivers in training. Thirdly, they may retain more men within the informal care sector and attract more youths into the sector.

Should they succeed, their next task would be to pro-actively campaign for a decrease in gender based essentialist and sexist notions attached to care work. Community-based caregivers are often peer educators as well as quasi-nurses. This provides an opportunity to alter sexist notions of work at the community level. In this way, a move towards more formal professionalisation will not insulate our men from gender essentialist stigma. Rather, the emotional (or most feminised) component of care may form the basis for the formation of this caregiver guild. As a result, informal caregivers, both male and female, will be recognised as emotional labourers. In this instance, the presence of emotions in work will be valued – but no longer gendered.

This may impact the meso-level normative structure, but may not necessarily impact upon the State. As Foucault warns, the presence of a Constitution does not prevent the hierarchical

organisation of the populace, for biopower operates within the stuff of life itself and regulates in an insidious manner. It suits the needs of the State to keep caregivers as a working army of non-organised workers that assist in palliative care (mostly for PWAs). Many soldiers in this army are unpaid volunteers for up to 5 years before they qualify for payment. Moreover, this mass acts as a reserve army of labour during public sector strikes (cf. Bechtel 2007: 1-2). Clearly, a highly exploitative situation has resulted and has been made all the more acute by a lack of caregiver mobilisation. If we continue to allow a sexist normative structure to remain, care will remain undervalued 'women's work'. Moreover, an idealised masculinity linked to professional status will persist and more black men will be driven from care work in an attempt to attain this elusive colonial reinvention. W.E.B Du Bois (1903: 4) said:

> [i]t is a peculiar sensation, this double-consciousness, this sense of always looking at one's self through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity.
>
> (W.E.B. Du Bois 1903: 4)

What we doom our men to is our contempt and pity, when human dignity is the least they deserve. More research of this nature needs to be done so as to help masculine caregivers to unravel a reinvented double-consciousness and to ensure that the gendering of work is helpfully deconstructed. Until this is achieved it would be careless to refer to black masculine caregivers as 'new black men'.

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