

Notes

1. Scheduled Castes (SC) and Scheduled Tribes (ST) are identified in the Constitution of India for special consideration in the form of protective discrimination/affirmative action. Scheduled castes, known as untouchables or *dalits*, occupy the lowest rung in the Hindu caste hierarchy. It needs to be noted that in Indian villages, although the SCs and STs live together with the upper castes, their habitats are often located on the outskirts of the village. The peripheral physical space they occupy within the village is reflective of the many layers of social and economic inequalities persistent in the Indian countryside.
2. Affirmative action has been a contested issue in India. It is seen both ways: as a transformative tool in liberal democracy, as well as a means to polarize the electorate in a democracy for political gain. Readings that illuminate these aspects include: Gupta 1998; Mahajan 1998; John 2000; Kumar 2001.

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Social Change and Community Participation: The Case of Health Facilities Boards in the Western Cape of South Africa

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This chapter investigates whether South Africa's post-apartheid legislation has had any significant impact on how Health Facilities Boards (HFBs) respond to the constitutional right of ordinary people, especially Black¹ people, to participate in the provision of healthcare services in their communities. It investigates community participation in HFBs by focusing on the historical context of participation in South Africa; the ideals of participation in the post-apartheid regime; the practices of participation; and the tensions that inform it. Analysis of two HFBs in the Western Cape suggests three possible reasons for the racially skewed nature of HFBs and why Black people in general do not participate in them. First, historically, whites have dominated institutions of governance in South Africa, including hospitals and their related structures. Second, procedures for the election of HFBs seem to favour literate and influential members of a community at the expense of poorer, largely illiterate members. Third, the culture of deference to professional authority undermines substantive dialogue and the empowerment of Black communities. Drawing on evidence from surveys of hospital users and interviews with hospital managers and members of HFBs, this chapter seeks to unravel some of the dynamics of exclusion from these invited spaces and explore some of the steps that might be taken to amplify the representation of hitherto excluded actors.²

Participation in Contemporary South Africa

Contemporary possibilities for citizen participation in South African politics are deeply shaped by the country's apartheid history. There were no legal rights or avenues for Black participation in political self-governance until 1994. The government was highly centralized, deeply authoritarian and secretive, and ensured that fundamental public services were not accessible to Black people. The struggle against apartheid took place outside the spaces of governance, and sought to mobilize community participation in order to transform South Africa's repressive government. Until 1976, a largely passive dream for liberation existed amidst unspeakable forms of oppression and exploitation. Dormant as its actualization remained, this allowed at least imagined spaces of participation.

The murder of Steve Biko in September 1977 signalled the need for not only community organization and mobilization at grassroots level but also community control. In subsequent years, spaces of community organization and mobilization multiplied throughout South Africa, culminating in the birth of the United Democratic Front (UDF) in 1983. The UDF claimed operational spaces against the apartheid state throughout South Africa, sustaining community forms of liberatory struggles at street and neighbourhood levels, often in the name of the banned liberation movements such as the African National Congress. From 1984 to 1989 the struggle against the apartheid state intensified, extending from local to international arenas, resulting in a range of divestment campaigns and cultural boycotts. This period created spaces of ungovernability throughout South Africa. The period from 1990 to 1994 saw the unbanning of the liberation movements and the beginning of the consensual politics of negotiation, leading up to and beyond the end of white minority rule.

The period since 1994 has been one of 'transitional governance', involving the negotiation of demands for democratization and deep social change. In this context, community participation has literally become synonymous with legitimate governance. This began with the negotiated settlement of a range of promissory spaces of participation, such as the Reconstruction and Development Programme of 1994 and the Constitution of South Africa of 1996: the former the outcome of community participation and the latter enshrining the right to participate in local government planning programmes.

From 1996 to 2000, the need for visible, experientially significant forms of social change gave rise to various types of 'development' partnerships mediated by socio-historical relations of power and trust, resulting in largely truncated spaces of participation. Since 2000, there has been a manifest shift from euphoria to disappointment, from generative hope to existential despair at the slow pace of change. Yet this despair, too, has given rise to new transformative spaces such as the Treatment Action Campaign, Jubilee 2000 and a myriad other local initiatives that seek to democratize politically liberated spaces. At present, then, community participation finds a strong place in rhetorics of governance, but with mixed results on the ground, as entrenched power relations shape the possibility of this participation being meaningful.

These broad dynamics play out in local government politics. Until the early 1990s, local government had no constitutional safeguard, as it was perceived as a structural extension of the state and a function of provincial government. In the wake of the abolition of apartheid in 1990, local government assumed an important role *vis-à-vis* institutional transformation. Thus, with a view to ensuring bottom-up, people-centred, integrated development planning at grassroots level, the South African constitution states that '[t]he objective of local government is to encourage the involvement of communities and community organizations in the matters of local government' (RSA 1996: subsection 152e). This is a radical posture, but one that encounters profound structural limitations in the midst of bureaucratic institutions and uneven relations of power.

There is reason for concern that in South Africa ordinary people serve mainly as endorsers of pre-designed planning programmes and objects of administrative manipulation in which bureaucratic elites impose their own truncated version of 'community participation' on particular communities. Consent for governance is not earned through rigorous policy debates of the merits and demerits of specific social programmes; rather, political acquiescence is manufactured through skilful manipulation by a host of think-tanks, self-styled experts, opinion polls and media pundits. Indeed, often community participation is managed by a host of consulting agencies on behalf of pre-designed, party-directed planning programmes and is quite clearly not fostered to empower local communities.

What possibilities exist, then, for meaningful spaces of participation? Some of the limitations of these spaces, and also some of their

possibilities, are evident in Health Facility Boards (HFBs), which are meant to contribute towards the institutional transformation of hospitals, yet are shaped and constrained by the complex legacies of institutionalized racism and exclusion. In what follows, I consider the operation of two HFBs, one at Heimwee Hospital, a peri-urban institution, the other at the rural Vorentoe Hospital, revealing both challenges facing spaces of public participation and ways of attempting to negotiate these challenges.³

Health Facilities Boards

The Health Facilities Boards Act of 2001 established HFBs as vehicles of institutional transformation – a way of ensuring greater community participation in the provision of healthcare services at grassroots level (Act 7 of 2001, sections 9 and 10). HFBs have broad mandates: they are responsible for approving the mission, vision and values of their hospital facility; advising in its management; strategic planning; monitoring performance; attending to patient grievances; fund-raising; appointments; and inspection (RSA 2001). The South African Medical Bill of 2003 reinforces these community-driven controls of healthcare. The Health Facilities Boards Act (section 6, subsection 4) makes it explicit that community representatives must constitute at least 50 per cent of an HFB. Theoretically, at least, this means that communities are now able to influence the formulation, implementation, monitoring and revision of hospital business plans, hospital staffing and the quality of hospital services.

HFBs represent vehicles for popular participation in institutional change not only because of their mandate and composition, but because of their link to Transformation Units (TUs). TUs were established by the National Department of Health in the late 1990s, at different levels of governance. Membership of TUs and HFBs often overlaps, although this was not an official requirement. Replaced in 2003 by Quality Care Committees, the TUs had significant institutional effects. The Deputy Director of Human Resources [Transformation] in the Western Cape suggests that TUs succeeded in making hospital management aware of *Batho Pele* ('People First') principles, established some cooperative relations with some hospitals such as Vorentoe and, in some small measure, brought people together across ethnic divides, at least to talk about institutional change at hospitals.

Yet a close look at HFBs shows the extent to which these participatory spaces of transformation remain hostage to their context, including the history of the institution and associated power relations, resource/capacity constraints, understandings of citizenship, norms and expectations of health services, and the material conditions of the surrounding population. HFBs operate in a context of profound divisions and glaring material inequalities, not merely between Black and white in general, but also between white and Black healthcare workers.

Demographic disconnections

The demographics of Heimwee hospital show the extent to which apartheid legacies shape contemporary conditions. The ethnic profile of patients is 5 per cent 'Whites', one per cent 'Indian', 29 per cent 'Black' Africans and 65 per cent 'Coloureds'. Top management, by contrast, consists of 66.6 per cent 'Whites' and 33.3 per cent 'Coloureds'. Middle management is a small step closer to representing the broader population: 13 per cent 'Whites', 3.4 per cent Black Africans and 82 per cent 'Coloureds'.⁴ This disconnection between hospital management and the demographics of the surrounding community is echoed in Vorentoe, where the former Municipal CEO trenchantly comments:

Their finances might well be in order, as they have been in order during the days of apartheid, but where is their transformation plan? How many Black doctors do they have? How many Black staff members do they intend appointing in the next few years in compliance with the government's requirement for 'demographic representivity' in public institutions? This is a new South Africa! It cannot be business as usual when under the guise of 'competency and experience' apartheid continues by other means!⁵

In keeping with this comment, we can note that neither the Heimwee nor Vorentoe Hospitals have a single Black medical doctor.

HFBs were brought into being as participatory vehicles for institutional transformation, yet the under-representation of Blacks in hospital management is mirrored in the HFBs themselves. The Heimwee local population is 19.6 per cent 'White', 30 per cent 'Coloured' and 50.3 per cent 'Black', yet the HFB, with ten members, is 40 per cent 'White', 50 per cent 'Coloured' and 10 per cent 'Black'.⁶ Members are between 50 and 60 years of age; and there are

almost twice the number of men as women. In Vorentoe there are fourteen board members – four women and ten men, between 45 and 55 years of age. They are all white except a priest representing the faith-based community in the village of Klawer (approximately 25 kilometres outside Vorentoe). Yet only 20.6 per cent of the area population is 'White', whilst 70.5 per cent is 'Coloured' and 8.9 per cent are Black Africans. HFB memberships are also skewed in favour of hospital management: in both Heimwee and Vorentoe the same nurses and doctors who constitute the majority in the HFBs are also part of the hospital management structures.

Recruitment to the HFBs is done via advertisements in the *Government Gazette*, calling for nominations from community organizations. Any nomination has to be accompanied by a verified copy of the constitution of the nominating organization. These procedures favour the historically well-connected white communities and exclude organizations without constitutions, such as Black youth organizations in Vorentoe and Heimwee. An absence of rules obliging the nomination of women, together with a historically entrenched patriarchy only recently beginning to be addressed, also ensures a relatively low proportion of women.

The implications of skewed membership for the conduct of HFBs comes out clearly in the comments of a senior Black male nurse at Heimwee Hospital, who rues the missed transformative possibility of HFBs: 'While the post-1994 health-related acts are very progressive, problems arise with regard to ensuring the rights of communities to participate in the healthcare service delivery programmes.' A key explanation, he suggests, is the relative economic privilege of those serving on the boards, which detaches them from an understanding of problems of service delivery:

When you look at the members of the HFB at Heimwee Hospital, most of the members, with the exception of one or two, do not use hospital services because they all have medical aid that provides them access to private medical services. This, in effect, means that their knowledge regarding services rendered, why they are rendered and to what extent they are rendered, is very sketchy. Therefore, their understanding of patient flow within the hospital is also suspect. I am not sure that they have a clear understanding of their role and function in respect of service delivery.

The nurse offers a picture of an HFB that is closely tied to hospital management, opaque to other hospital constituencies, and unconnected to grassroots perspectives and needs:

The personnel have never had any introduction to the HFB members and minutes of meetings have never been circulated. There has never been a suggestion or enquiry from the HFB to improve some aspect of service delivery. For example ... no one has ever asked what would be needed to improve patient waiting times.... It could be that hospital management gives the HFB satisfactory answers in their monthly meetings. It could also mean that the question never was asked because of lack of insight on the part of the HFB. Health is always a very contentious issue and therefore there are always a myriad questions, even from the most illiterate of people, and the HFB is supposed to represent the people, be their mouthpiece so their voices could be heard at a platform that could give some validation to their plight. Unfortunately this does not seem to be the case.... Many people are not even aware of the HFB's existence.⁷

A case in point is the presence of a white-owned security company at Vorentoe Hospital, appointed by the white management staff of the hospital, controlling the visiting hours of predominantly Black patients. According to the only Black councillor on the HFB, this company frequently prevents Black families from visiting their sick relatives in hospital, causing them to phone him in the middle of the night to address their frustrations. In the councillor's own words, 'Why do they have to do this to poor people? Where is their respect for the basic rights of patients and their family members? Why should families have to call me to sort out this totally unnecessary form of power, of control, and abuse?'⁸

During the interviews it was made quite clear that Black people do want to participate on HFBs as they are mostly poor and dependent on these hospitals for healthcare, whereas most whites can afford private care. Influencing HFBs, their agenda, their decisions, their programmes and their daily activities is therefore necessary to advance the interests of the essentially poor Black communities they serve.

Sustaining the Status Quo?

It is not only the composition of HFBs that works against their being agents of institutional transformation. Their culture and design also serve to perpetuate the dominance of whites, and sustain existing hierarchies of power and privilege. A first of such features of HFBs concerns rules for formal agenda-setting and control of topics: the board secretary constructs the agenda, although nominally every

board member can introduce issues. The chairperson of the board is equally influential in determining the extent to which issues are discussed or whether they are immediately referred to a subcommittee for further investigation.

A second feature involves the dynamics of authority and deference. It seems that often issues are not discussed with the requisite rigour for fear of offending people of significant social standing on the board. Moreover, HFB members typically participate as recipients of information: they are told what has been decided or what has already happened. It was announced without discussion, for example, that ward C in Vorentoe Hospital had been privatized to cater for the needs of patients who could pay for medical services.

Third, the procedures and protocols of HFBs are inflexible and ritualized. Ms Archer, a senior citizen and former nurse, spoke eloquently of the constraining protocols of these meetings at a board meeting of April 2002:

This is how we speak,
This is how we look,
This is the image we want to project,
This is taboo to us,
This we do not tolerate.⁹

The culture of HFBs conditions not only the topics that arise (what is sayable and unsayable), but how topics are treated. Introducing a topic with a sense of seriousness or with nonchalance influences its course. For example, the issue of the Vorentoe October musical festival was introduced casually to the board, belying the fact that it is a contested calendar event, largely unlegitimated by the Black community.

Assessing the Contribution of HFBs

The composition, structure and design of HFBs together work to limit their accomplishments. Their ostensible aim was to make hospital services more responsive to the needs of surrounding communities by giving members of those communities an active, participatory role in policymaking. Yet there has been far too little movement on the part of hospitals to respond to the needs of the most impoverished

and marginalized groups. Health needs of Black residents in both Heimwee and Vorentoe, who confront unemployment and poverty levels ranging from 50 to 70 per cent in some communities,¹⁰ are wide-ranging and include malnutrition and related diseases. The attention of the boards, however, is on matters quite distant from the most pressing community priorities. The Heimwee HFB, for example, appointed two psychologists in a hospital where none of the patients has behavioural problems. In the words of one senior Black nurse, 'one psychologist would still have been a nice-to-have, two is certainly extravagant!'¹¹

The overall orientation of HFBs is towards narrowly defined management goals, and particularly goals of fiscal discipline. Indeed, Vorentoe prides itself on being one of the few hospitals in the country that regularly records financial compliance with the statutory requirements of sound governance. Yet its model of effective management is flawed in the sense that not only do the hospital's decision-making powers remain unconnected to the communities they serve, but its effectiveness is also measured with barely any reference to the Black community who constitute the majority of its patients. A Black nurse at Vorentoe comments: 'To a certain extent the HFB serves a purpose, but they really do not make a contribution to society as a whole. They do not go out to the public and ask them what they want. They only implement things they think the community needs.' In both the Heimwee and Vorentoe hospitals there appears to be a 'charitable' attitude among white HFB members that serves to reduce the concept of public participation to an efficiency model of financial management.

Whose Voice? Issues of Inclusion and Representation

One of the most pressing challenges that emerges in this context is to make sense of the dramatic under-representation of Blacks on HFBs. Previous studies, as well as the research on which this chapter is based, point to a tension between the apparent efficiency of healthcare services and residual racist attitudes, lack of communication and indeed lack of opportunities to participate in HFBs. Further dimensions emerge when we distinguish between representation of Blacks from the community at large, and from the community of healthcare workers.

From the community at large

Though the Athlone community, a predominantly middle-class suburb of the City of Cape Town,¹² in general favours public participation in the delivery of healthcare services, not a single respondent could cite an example where they were consulted by healthcare workers, or a committee meeting that engaged them on issues of service provision. Rather, members of the Athlone community are strikingly unaware of HFBs as vehicles for possible participation. Indeed, a study we began on patient attitudes towards HFBs was redesigned to focus on nurses once we discovered that no members of our initial sample of patients at Heimwee Hospital even knew that HFBs existed. We surmised that if patients themselves do not know about the existence of the HFB, it is likely that the surrounding Heimwee communities, especially the historically disadvantaged ones, are also largely ignorant of it; and that in Vorentoe and elsewhere in the Western Cape the situation is likely to be similar. Lack of effective communication of the existence of HFBs in these areas clearly contributes to the lack of participation in them by Black communities.

Our survey in Athlone showed that members of the community get their information about health services through complex communication networks. Almost a third (32 per cent) of the residents indicated that they get healthcare information through their families; 30 per cent through health professionals; 26 per cent through the community, and 12 per cent through friends. Newspapers and radio seem much less effective in communicating information about health services to the community, and yet it is these avenues that were employed in publicizing HFBs.

The creation of HFBs was preceded by awareness-raising programmes through advertisements in the daily newspapers, local community newspapers, and by information sessions on public radio stations. According to the Deputy Director, Legal Adviser in the Health Department of the Provincial Administration of the Western Cape, the response from Black communities was 'pathetically low' especially in areas such as Vorentoe. In his view, urban areas such as Cape Town had a much better response rate, as reflected by the greater 'ethnic balances' on the HFBs in Metropolitan Cape Town.

The limitations of newspapers as vehicles for raising awareness of HFBs in the broader community are reiterated by an Anglican priest who has lived in the area for more than thirty years:

Black people are very poor in Vorentoe and cannot afford these [news] papers. Also, the legacy of the apartheid mindset in Vorentoe is still very strong and therefore whites generally do not communicate with Black people on an equal footing. Indeed, there is a need to involve civil society organizations and the churches in particular to draw the people's attention to their constitutional right to participate in the provision of healthcare services in their communities. People will indeed participate if they are granted the opportunity to do so.¹³

The combination of inappropriate mechanisms of publicity and intercommunal division and lack of trust in excluding Blacks from participation on HFBs is substantiated by comments from the Deputy Director of Human Resources and Transformation for the West Coast Winelands Region, Malmesbury:

Black people are generally poor, and cannot afford the newspapers. Consequently, they do not know of the invitation to serve on the HFB. There is no other form of communication with people at grassroots level. This means white people are able to dominate the nomination/election of the HFB. And because Black and white people do not interact beyond a master-servant relationship [domestic servants/maids], the election of the HFB is not made known to the poorer sections of especially the Black communities. We must not forget that apartheid divisions still exist and the only contact that whites have with Black people is still largely through their domestic servants/maids, surely not a good measure of the leadership potential of politically literate, educated Black people. More importantly, perhaps, both in Vorentoe and Heimwee, Black people simply do not trust whites!... Thus talking about cooperation is still merely talk.¹⁴

The role of internalized racism in reinforcing Black exclusion from HFBs is brought out by comments from a young Black businesswoman in Vorentoe, who described Black non-participation in socio-historical and psychological terms:

Black people do not participate because they feel inferior to white people. Participation requires special knowledge and Black people do not have the necessary knowledge to engage white people on matters such as health. These negative self-concepts are reinforced by the fact that Blacks and whites do not mix. In short, Blacks and whites do not trust each other. Still, if Black people do get the opportunity to participate on the HFB, they most probably will do so.¹⁵

The exclusion of Blacks from HFBs can also take place through more direct and intentional forms of racism, as this narrative from a Matzikama Municipal Counsellor on the Vorentoe HFB reveals:

It is an error to assume that apartheid is over. This is not true.... When nominations were invited for the present HFB, I was nominated as chairperson of the HFB. The white people came to know about my nomination and did not like it. Indeed, they consider the hospital their property. They consequently lobbied the powerful Dutch Reformed Churches – of which there are two in Vorentoe. And, given their resources and influence, the white community managed to re-elect van der Spuy as the chairperson, for the fifteenth year running!

Interestingly, our survey in Athlone shows a high level of satisfaction with health services: 92 per cent of the respondents considered healthcare services to be adequate, and only 8 per cent disagreed. However, satisfaction with health services does not mean satisfaction with the range of services. During follow-up interviews with some participants a need for a holistic approach to healthcare was expressed, as well as for specialist services. For example, it was suggested that poor tuberculosis patients need meals as well as direct observation treatment (DOT); an eye clinic was also identified as a need.

Survey respondents clearly supported community participation in healthcare: 46 per cent of the respondents indicated that the community should have the final say in decisions affecting healthcare service delivery, whilst exactly the same proportion said that healthcare professionals should have the final say. Some 18 per cent said that decision-making should be a partnership between healthcare workers and the community, and only 6 per cent said that they did not know. When it came to what 'participation' meant there was more unanimity: 80 per cent of respondents said that community participation means involvement in decision-making about the types of healthcare services.

That there are opposing views on community participation in healthcare suggests that the Athlone community is not a monolith, even though it is largely a 'Coloured' middle-class constituency. Participants vary, not merely in terms of their gender, ethnic background, language use, religious affiliation and knowledge base, for example, but they also have differential access to information and ability to make sense of it. These differentiations shape different understandings of and perspectives on community participation. Indeed, some middle-class residents may feel that since they pay taxes they are entitled to good healthcare without the additional effort of participation in the governance of health services. Social differentiations such as these also shape the likelihood of participation being effective in ensuring

good healthcare, especially among Black communities. One senior Heimwee nurse identified lack of access to capital resources on the part of some communities as a major reason for the failure of one community-private partnership in healthcare:

In a predominantly 'Coloured' lower-middle-class community in Eerste River, some 25 kilometres outside Cape Town, there were attempts to introduce private health care, based on a community-private partnership. Very soon, however, cashflow problems emerged and this community had to abandon the partnership ... and refer their patients to Tygerberg Hospital.... Unless you are well-connected to largely white capital, as is the charity organization Heimwee Hospital Action Group, which raises money for the Heimwee Hospital, whatever partnerships are launched are bound to fail. For historical reasons, there is ... a very strong relationship between private capital, sound health care and sustainable public-private partnerships. It is access to these forms of capital that Black communities must seek to secure to ensure sustainable and meaningful public-private partnerships.... Unfortunately, at this point, white capital still largely controls both the form and substance of these partnerships. This is also the case in Vorentoe, where Ward C has been privatized for the use of both Black and white private patients.¹⁶

From health practitioners

HFBs include representation from the community at large, and also from members of the hospital community. The above discussion reveals how ineffective publicity, formal and informal exclusion, and internalized racism all play roles in keeping Black members of the community at large from participating on HFBs. What, though, of Blacks on staff at hospitals?

In Heimwee, twenty nurses (nineteen Black and one white) were each asked about the extent of their knowledge of HFBs, their willingness to participate in them and their general opinion of them. Knowledge of the boards was widespread: with the exception of one nurse, all knew of the existence of the HFB. There was, however, a relatively low level of unconditional willingness to participate on the HFB: 25 per cent said they would participate; 20 per cent said they would participate conditionally; 35 per cent said they would not participate, and 20 per cent said they did not know.

Reasons for willingness to participate included the ability to influence the HFBs' agenda and activity programme. Reasons for unwillingness included time-consuming jobs in a situation of staff

shortages, as well as worries about the effectiveness of HFBs in influencing hospital priorities or working conditions. One interviewed nurse identified the Union as a potentially more effective site for negotiating service provision policy as well as working hours and career support.

Prospects for Change?

The above analysis offers a pessimistic portrayal of HFBs: notwithstanding their broad mandates for institutional transformation of hospitals, the boards have tended to focus on a combination of trivial issues and management concerns, while paying little attention to the pressing healthcare needs of the broader population, and especially of Blacks. Our analysis has suggested that the failure of HFBs to act as transformative institutions is connected to the narrowness of their membership, with Blacks dramatically under-represented and hospital management over-represented.

Yet the story is not entirely negative: since their creation, HFBs have managed to enact positive changes that provide grounds for hope. The entrenchment of fundamental rights in the South African Constitution, and broader social and political movements towards institutional change, have attuned the HFBs to pressures for transformation, resulting in the creation of a Transformation Unit at some hospitals such as Vorentoe. There the hospital representative has already attended several workshops, as a result of which the management has established contacts with other hospitals experiencing similar transformation challenges. Similar contact networks have been formed with local, provincial and national governments, for example in Malmesbury, Heimwee and Cape Town. The approach to healthcare has changed from being curative in nature to one that is primary and holistic, addressing the impacts of socio-economic issues such as unemployment and poverty on the well-being of the community. Vorentoe, for example, now supports a rural clinic programme.

The minutes of HFB meetings are also becoming considerably more detailed and are providing a more comprehensive account of board activities. This may reflect a movement towards greater democratic commitment. Moreover, the presence of *any* Black community members on HFBs is a lesson for white participants: by

sharing institutional space with their historically separate 'White' counterparts, these (predominantly middle-class) Blacks demonstrate to racial bigots that it is possible for Black and white to cooperate at local level, even if the HFBs do little to address the most pressing Black community concerns.

The under-representation of Blacks at HFB meetings is also officially recognized as a problematic reiteration of historic patterns of exclusion: the Department of Health is currently concerned to construct and present public participation programmes at the hospitals under its jurisdiction.

Towards More Inclusive Representation

The key question, then, is how the membership of HFBs can be rendered more representative of the broader community, so that the participatory, transformative intent of these democratic spaces can be more fully realized. There is a widespread view, articulated in many of the interview narratives, that there would be a strong willingness on the part of Blacks to take part in HFBs under the right conditions. As a young Black businessman in Vorentoe stated: 'If there is an opportunity for Black people to participate on these boards they will definitely do so.'¹⁷ This conviction finds support in the literature: Patterson (2000), for example, argues that non-participation in community representative spaces does not necessarily mean apathy towards the democratic process. On the contrary, entering space as a subordinate, unfamiliar with the forms and meanings of deliberative discourse and hidden transcripts, undermines participation as a rational, open and empowering democratic practice.

Our analysis reveals a number of changes that might encourage participation by marginalized members of communities and hospital staff in HFBs. We have seen the limitations of conventional forms of publicity in informing poor and marginalized Black communities of the existence of HFBs as invited spaces: poor communities cannot afford expensive daily newspapers and have limited access to radios and television. Informing this population of HFBs as avenues of transformative participation thus requires other, more effective and accessible means of communication, which might include rallies, flyers, door-to-door visits and so forth. This lesson accords with the broader claim that in poor communities informal communication

strategies (such as street theatre) can serve to conscientize and inform the marginalized about community issues and their rights vis-à-vis public institutions (Bratton and Alderfer 1999).

Our analysis shows how both subtle and overt forms of racism, as well as internalized racism, shape the ability and propensity of Blacks to serve on HFBs. This dynamic is likely to be aggravated by associations of healthcare with charity and paternalistic provision, whereas in fact healthcare is entrenched in the South African constitution as a legal right (section 27; RSA 1996). Treating both healthcare and participation in HFBs as rights, to be defended and used as such, might constitute an important vehicle to encouraging and securing greater Black participation.

The dominance of privileged elites in the current operation of HFBs is reinforced by aspects of the culture and design of these spaces, including the authority over agendas possessed by secretaries and chairs, dynamics of authority and deference, inflexible and ritualized procedures and protocols, and the tone that surrounds the treatment of topics. In order for poor, historically marginalized communities to participate in HFBs, the social relations of power undergirding these invited spaces must be opened to critique, and procedures rendered sufficiently flexible and open-ended to accommodate a broader range of participants and topics.

Steps should be taken to ensure that HFBs as invited spaces are not dominated by the articulate middle-class and conscious members of the community, but that working-class constituencies are directly involved in the formation of community participatory spaces. For this to be realized, changes in the rules of representation are required. The current practice of nomination of registered organizations should be replaced by the election of representatives from among all users, with the reservation of seats for women and Blacks. Greater publicity is needed to ensure that a broader section of the community are aware of the HFBs and their role, and are able to put themselves forward as candidates. Proactive efforts are needed to change the racial balance, seeking out Black community organizations such as taxi associations, ratepayers' associations, community police forums and youth groups in Heimwee. In Vorentoe, where there are virtually no civil society organizations in Black residential areas, political parties and the Farm Workers' Advice Office could function as a catalyst to organize and mobilize poor people to claim their constitutional right to be represented on HFBs.

The above steps to transforming the membership and procedures of HFBs can each be fostered in so far as community organizations serve as intermediaries between the boards and members of broader communities. Recall the voice of the Deputy Director of Human Resources and Transformation for the West Coast Winelands Region, who pointed out the gulf between Blacks and whites that perpetuates exclusion on HFBs; he goes on to say that

Attempts must be made to bring the two groups together. And, in my view, this can best be done through youth networks. In this regard, the churches in both rural and urban areas are starting to play a role. Indeed, building social relations based on trust and human solidarity, even if it must be done primarily through the churches, is perhaps the only genuine way to move away from white racism and Black oppression. In the fullness of time these 'new' relationships will affect how institutions in South Africa are run, including the composition and management of HFBs.¹⁸

Conclusion

This chapter has identified three possible reasons for the racially skewed nature of HFBs: the historical dominance of whites in institutions of governance; the procedures for election which favour the literate and influential; and the culture of deference to professional authority which undermines substantive dialogue.

It has also pointed to reasons for hope: more representative, less hierarchically structured HFBs could be dynamic networks of dialogue and engagement, triggering feelings of identification, trust and self-reliance in opposition to historical paternalism in healthcare and the infantilization of Black people in general. There are nascent signs of trust emerging. These take three forms: identification with the need for participation; the development of solidarity and collective engagement on issues; and increased self-reliance and achievement, which can induce people to take public participation seriously – if provided the opportunity to participate.

Thus pursued, participatory spaces would, indeed, constitute living community networks of engagement, reflection and transformation. More than 350 years of a charitable stance towards Black participation in institutions of governance preceded the formation of HFBs at the dawn of the twenty-first century. Thus, only the future will tell whether or not Blacks will indeed become co-shapers and governors of their lives via HFBs, not merely in policy design but in practice.

Notes

I wish to thank David Kahane for his valuable contribution to this chapter – he translated my turgid prose into readable, coherent and concise text. However, all remaining errors are mine.

1. The South African Constitution, Act 108 of 1996, describes the historically disenfranchised sections of the population, the Africans, 'Coloureds' and 'Indians', as 'Black'. For the sake of historical and textual clarity, this chapter also refers to the apartheid racial categories of 'Blacks' (African), 'Coloureds' and 'Indians', while recognizing their sociological and scientific weakness.
2. This chapter is based on fieldwork carried out in the Western Cape in 2003–05, using a mix of survey and interview methods. It also makes use of the results of a 2003 opinion survey on community participation in the provision of healthcare in Athlone, historically a 'Coloured' middle-class suburb of the City of Cape Town (Mabuya 2003).
3. Both of these hospitals have been given fictitious names.
4. Source: Hammers, Garfield, information provided on request, 2004.
5. Interview, 9 July 2004.
6. Source: Hammers, Garfield, information provided on request, 2004.
7. Interview, 24 May 2005.
8. The Security Company usually relents after the Councillor's intervention – i.e. it allows Blacks to visit their sick family members.
9. Source: Archival records: Health Facilities Board Minutes, 11 April 2002.
10. Respectively Stellenbosch and Vorentoe Integrated Development Plans, 2004/05, supported by interviews with councillors from these municipalities.
11. Interview, 23 August 2005.
12. The City of Cape Town does not have an HFB, but a Medical Officer of Health, who is responsible for healthcare services in terms of the City's Integrated Development Plan. Community participation takes place in terms of the Municipal Systems Act, Act No. 32 of 2000, which regulates Integrated Development Planning.
13. Interview, 20 May 2005.
14. Ibid.
15. Ibid.
16. Interview, 23 August 2005.
17. Interview, 20 May 2005.
18. Ibid.

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