

INTEGRATION IN SOUTH AFRICA: A STUDY OF CHANGES IN THE COMMUNITY HEALTH SYSTEM

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A thesis submitted in fulfilment of the requirements for the degree of Doctor
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KEYWORDS

South Africa

Primary Health Care

Health Service Integration

Apartheid

Community Participation

Community Health System

Dominance

Resistance

Patronage

Facilitator/Magician



Abstract

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In the thesis, I analyse a facilitated pilot project of integration of health care services at the community-level. The importance of the thesis is justified by three reasons: firstly integration and the creation of a district health system, as envisaged under Primary Health Care, is promoted as the solution to the health inequalities inherited from Apartheid in South Africa. However, many pilot integration projects have failed and analysing a failed project from an anthropological perspective provides valuable insight. Secondly a renewed interest in Primary Health Care, as the World Health Report of 2008 sets out, also makes this a pertinent pursuit from an international viewpoint. Thirdly the human experience is often ignored in health reform literature.

I argue that anthropology can provide valuable insight into integration processes in a health system. Because anthropology explores the human experience, it provides a detailed understanding of the changes in a community health system and their impact on all role players.

The data presented in the thesis were collected in an ethnographic community-level study in one township urban South Africa between October 1999 and October 2002. This makes this it a historical piece of work to a degree. I describe and critically analyse the facilitated process from the start of the project in October 1999 till its disintegration in failure in June 2001. I also describe and analyse the findings from community research conducted in 2002.

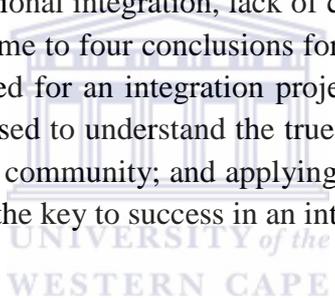
For the analysis, firstly I build upon Scott's concepts of dominance and resistance from his book *Dominance and the Arts of Resistance* to construct a framework. I argue that to understand a change process fully requires considering the historical context, the international arena, the present context and the facilitator.

Secondly, I build upon Schuyt and Schuijt's ideas surrounding consultants/magicians from their article entitled *Rituals and Rules: about magic in Consultancy*. I apply the ideas around Space and Place as considered in *The Anthropology of Space and Place: Locating Culture*. I use both these ideas to analyse the planning process and the role of the facilitator in this process.

Thirdly, I continue working with the concepts of dominance and resistance to analyse the motivations and behaviour of managers, staff and the community in the project. I engage with critique that these concepts promote a binary view of power which fails to account for other aspects of social life. I argue that by taking these other aspects into account, dominance and resistance can be useful as concepts in analysing the integration process.

Finally, I conclude the thesis by considering how the findings can provide insight for future integration processes. The analysis showed that the role of the facilitator was not sustainable, managers' lack of commitment was due to their lack of power and belief in the success of the process, and staff resistance emerged from the functional integration, lack of clarity on the process of change and lack of power. I come to four conclusions for other processes: it is vital that the context is considered for an integration project; the concepts of dominance and resistance can be used to understand the true motivations behind the acts of managers, staff and the community; and applying Kayizzi-Mugerwa's definition of ownership might be the key to success in an integration project.

August 2014



Declaration

I declare that *Integration in South Africa: A Study of Changes in the Community Health System*, is my own original work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.



Jennifer Parr

August 2014



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Dedicated to L.D.A. Romijn 10-10-1952-14-08-2012 P E

Disclaimer

The opinions expressed in the thesis are those of the author and do not necessarily reflect the views of any organisation or institute involved or associated with this research project.

Please be advised that the names and/or identity of everyone involved in the project have been changed. This includes the names of the community and the NGO involved in the project. This is in accordance to the requirements of ethical approval.

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List of acronyms

ASA	Association of Social Anthropologists
CHC	Community Health Centre
CNP	Clinical Nurse Practitioners
DHS	District Health System
DoH	Department of Health
NGO	Non-Governmental Organisation
NUFU	Norwegian Programme for Development, Research and Education
PHC	Primary health care
SAHA	South African Health Alliance
WHO	World Health Organization

Chapter 1 - Introduction

1.1 Background

The South African health services reform legislated under the 1996 Constitution has been hailed as one of the most comprehensive and progressive steps towards addressing health inequality (Kautzky and Tollman, 2009). The reform promoted integrating curative and preventive health services and creation of a district health system, ultimately leading to comprehensive system of primary health care (PHC) as formulated by the World Health Organization (WHO) at Alma Ata in 1978 (WHO, 1978, Couper et al., 2003). PHC aims to use scarce resources optimally by uniting existing structures, resources and activities in the health system. This integration is considered the means to address the inequalities plaguing the South African health system, inequalities that stem from a legacy of segregated health care delivery. This segregation entailed a division of health services under provincial authority, i.e., curative services (e.g., hospitals) and services under municipal authority, i.e., mainly preventive services (e.g., family planning).

The Apartheid era resulted in a health system characterised by “racial discrimination, fragmentation, poor coordination, duplication of services and a predominant focus on hospital-based care rather than primary care” (Benatar, 1997, p.891). To highlight some of these issues: each district, for example, has its own organisational structure and therefore will present different challenges in the integration (Health Systems Trust, 1999, SAHA, 2003, Couper et al., 2003). Some health centres consist of three health services such as a day hospital, clinic and separate midwife obstetric unit. Some areas have non-governmental organisations (NGOs) involved in PHC activities, such as a district with a 24-hour comprehensive clinic and an NGO day clinic (Bachmann, 1999, Couper et al., 2003). Besides the different health services and authorities operating in each district, districts will have to deal with varying workloads, resources, staff turnover and community safety concerns.

To address these challenges the South African Government implemented health reform based on the primary health care principles through the creation of a decentralised District Health System legislated in a 1997 White Paper (Department of Health, 1997, Petersen, 2000, Pillay, 2001). To test the viability of this health reform, several pilot projects were commissioned. A working relationship was formed between the South African Government and South African Health Alliance (SAHA), an NGO, to facilitate these pilot projects. NGO involvement was seen as important in a bottom-up approach to health-system reforms. As well as being a principle of PHC, a bottom-up approach helps address the Apartheid legacy of no voice for disadvantaged groups.

Previous pilot projects identified major challenges in the managerial and organisational side of the reform process. Forming a single local health authority proved to be more difficult than anticipated. Restructuring of the local government progressed at a different pace than the changes in the health services. Another major challenge was the continuing disparities in salaries and benefits between provincial and local government (Pillay, 2001). Many pilot projects were consequently labelled abandoned due to failure by the SAHA and the Department of Health (DoH). Problems encountered during integration included staff resistance to change and power struggles between local and provincial government. A lack of consultation and support for the staff involved were found in projects in the Western Cape, the Free State and the Kalahari district, Northern Cape (SAHA, 1999). SAHA (2003) suggests that projects need two important structures to succeed: a permanent management team and supportive national and provincial health departments. The document states that each district had different experiences but “the above lessons were shared by all” (SAHA, 2003, p.2).

1.2 Aim and justification

This thesis focuses on the Paradise Park integration pilot project: a pilot which (it was assumed initially) would learn the lessons of these previous failures and therefore

succeed. Initially the thesis aimed to examine the impact of the integration on nursing practice and knowledge. However as my research project developed, it became clear that this focus would be too narrow as the impact of the integration included other parties such as the facilitator, the managers, all staff members and the community and their interactions. For the thesis I wish to describe the facilitated process between the start (October, 1999) and evaluation (June, 2001) of the project. The aim of the thesis is to show the insight anthropology can provide in understanding the processes of integration.

Integration and PHC are once again at the forefront of the discussions in the international health arena with the 2008 World Health Report (WHO, 2008) calling for a return to the Primary Health Care approach. A renewed interest has been sparked, therefore, in the key principles and the manner of implementation of PHC. These aspects are relevant particularly to South Africa where health outcomes remain below par despite a relatively high (8.7%) of gross national product being allocated to the health sector (Kleinert and Horton, 2009). This poor performance is due partly to the weak health system (Kleinert and Horton, 2009). PHC and its implementation need to be reviewed continually and new insights sought. Important lessons can be learned from the pilot projects assessing health-sector reform in South Africa before roll-out to the rest of the country.

Blaauw et al. (2003) in their background paper highlight how public health, in portraying health reform, has been more focused on economic and technical elements and has generally ignored the human dimension. Organisational and institutional theory have long recognised the need for attention to the human element in organisations (Blaauw et al., 2003). There are exceptions, and particularly researchers in South Africa have been exploring the human element in health sector reform and, with their work, emphasise the need to bring this element into focus (Blaauw et al., 2003). These South African studies include Schneider's (2001, 2002) work on policy implementation and the influence of macro-level factors and Penn-Kekana et al.'s study (2002) on listening to the voices of senior and middle managers. One of my fellow researchers in the

larger project and introduced below in this section, Froestad, provides another good example with his study of trust among staff (Froestad, 2005b). A further literature search reveals several other influential writers in South Africa including Uebel et al. (2013, 2010) on integrating HIV care into primary-care services and Gilson et al. (2005) on trust in relationships between patient and provider and health worker and employer and their influence on health-system responsiveness.

Anthropology has long been interested in organisations and the human dimension. The Hawthorne experiments and the Manchester shop-floor studies are early examples of this interest in anthropology (Wright, 1994). Although the Hawthorne experiments are perhaps more known for the Hawthorne effect, the later stages of the experiments helped to develop observation techniques and highlight the possibility of applying Radcliffe-Brown's social system in which actual interactions form a systematic whole to analyse organisations (Wright, 1994). A book edited by Wright (1994), for the first time, brought together anthropologists interested in studying organisations and provides several examples of the contribution of anthropology to the study of organisations and reform in organisations and institutions. These are organised in three main themes, including indigenous management which considers indigenous styles of management versus bureaucratic and universal systems, gender and organisational change considering widespread inequality in private and public organisations, and clients and empowerment in state institutions. By applying ethnographic methods and analysis, these studies provide insight into the human element of organisations and organisational change (Wright, 1994, Blaauw et al., 2003).

To return to health, Janes and Corbett (2009) provide a comprehensive overview of the contributions of anthropology to global health including to the interrogation, analysis, and critique of international health programs and policies, under which this thesis falls. These authors list a large number of studies which highlight the challenges of policy implementation around the world. The other researcher, who is a medical anthropologist, in the larger project and introduced in this section below, has written on patients' experience in hospitals during health reform described above in the

introduction (Gibson, 2001, 2004) and on the creation of trust among actors in the health information system. The literature review did not reveal similar studies to the one I propose in South Africa.

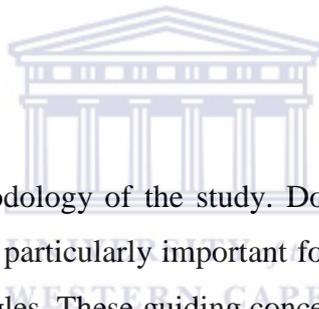
The great strength of anthropology lies in its exploration of human experience without narrowly focusing on one single aspect of social life. By analysing not only the pilot project but also the context of the project, a much fuller picture emerges. The short literature review above has shown that exploring the human experience from the point of view of health-reform research is welcome (Blaauw et al., 2003). The strength of ethnography, the chosen approach for the thesis, lies in allowing the meaning of the experience of the change process to emerge from the fieldwork process and works without a-priori codes. In this case, in Paradise Park between October, 1999, and June, 2001 (for further discussion, see Chapter 3 Methodology). The thesis considers the historical and present context of the coloured community, the development of nursing practice, the developments in PHC in the international arena of health and influences such as power, gender and age. This consideration provides a broad understanding of the changes in the health system and their impact on all role players. As Askvik and Bak (2005), in their write up of the larger project this thesis is part of, highlight, the main operationalisation and implementation strategies are best understood in relation to the local context; particularly, the legacy of mistrust in institutions.

This larger project is the Administration South Africa Project (1999 to 2003). This was a multidisciplinary research project funded by the Norwegian Council for Higher Education's Programme for Development Research and Education (NUFU). The project promoted collaboration efforts between the University of Bergen, Bergen, Norway and the University of the Western Cape, Cape Town, South Africa. The project focussed on the issue of trust between members of the public and public institutions in South Africa (Askvik and Bak, 2005). The project included five theme groups representing the public institutions (namely legislature, local government, land, housing and water, education and health). For the health group, three researchers investigated different levels of trust in health institutions.

- a) Jan Froestad from the University of Bergen examined how lack of trust in the health sector causes organisational problems (Froestad, 2005b).
- b) Diana Gibson from the University of the Western Cape focused on the creation of trust in the health-information system (Gibson, 2005).
- c) My research aimed to investigate trust as it informed the implementation process of the integration of the health service at the community level.

Findings from the first two researchers' investigations provided insight in the provincial and local levels of governance during the process of integration. My thesis only engages to a limited extent with their findings and instead focuses on an ethnographic study I did at the community level during the pilot project in Paradise Park.

1.3 Thesis structure



Chapter 2 describes the methodology of the study. Dominance and resistance are the guiding concepts of the thesis, particularly important for a country such as South Africa with its history of power struggles. These guiding concepts will be discussed in Chapter 3. This Chapter also provides the context for the project by discussing the framework in which dominance and resistance can be understood. This includes four elements:

- a) The history of Apartheid and the development of Paradise Park under forced removals.
- b) The international arena from which the impetus to create PHC stems and the development of nursing practice under Apartheid.
- c) The landscape of contrasts in which Paradise Park resides as a result of forced removals and the present context of Paradise Park itself.
- d) My own role as a facilitator and my background.

With this understanding of the context it is then possible to consider the planning of the integration pilot project in Chapter 4. This chapter considers the central role of the facilitator in the planning of the pilot project and the roles assigned to the role players

(i.e. the managers, the staff, the community and myself as the co-facilitator.) Chapters 5 and 6 then analyse the events during the facilitated process in Paradise Park. Chapter 5 examines the role of the managers and Chapter 6 examines the roles of staff and the community. Chapter 7 recounts the events surrounding the end of the project, including the evaluation by management and an account of the Paradise Park facility in 2006. The Conclusion in Chapter 8 then refers back to the aim of the thesis to highlight three issues which show how anthropology can provide insight into integration processes.



Chapter 2 - Methodology

2.1 Introduction

Included in this chapter will be sections on the research approach chosen for this research, the research design, the analysis, and dissemination. The last two sections will explore ethics and limitations.

Ethnography, both methods and the written product, can be seen as an open-ended, iterative, and reflexive learning process (Whitehead, 2002, 2005). There is some preparation and consideration of themes and ideas but most importantly the fieldwork process reveals the components of the cultural system being studied (Geertz, 1973). This type of fieldwork process is inductive in nature and entails that in terms of research design the study is more about a continuous process of finding out what questions to ask than it is about how to ask these questions (Whitehead, 2002). As such, during the fieldwork period, the researcher needs to be flexible and go with where the study takes them (Whitehead, 2002). At the same time it is important to continually question one's own interpretations and biases as the researcher (Altheide and Johnson, 1996). Although this thesis includes a methodology chapter, in ethnography it is more common to let the narrative explore what was done and how it was done incorporating methodological considerations in a natural manner. Therefore this chapter is relatively short while the narrative of the thesis explores elements in more depth.

2.2 Research approach

The approach taken for this study is ethnography, which is evident both in the research design and the product which constitutes this thesis. The reason why this approach was chosen is related to my role in the larger project of the Administration of South Africa (see section 1.2). My task was to investigate the implementation process of the health

service at the community level and to take an active role in this (see section 3.6). Immersing myself into the process and into the community seemed the most logical approach from my background as a medical anthropologist. It would allow me to gain in-depth knowledge of how and what people in the project and community believe and why they behave the way they do (Green and Thorogood, 2006, Bryman, 2001). Naturalism is a strong element in ethnographic methods. Over time, my being part of the project and the community would, hopefully, minimize the impact of being studied by me.

The study was conducted between October, 1999, and October, 2002, with a short follow-up in 2006. I did not live in Paradise Park during my research as classic anthropological immersion is perhaps defined but immersed myself through participant observation and several other data-collection methods which will be described in section 2.3.

As is evident from section 1.2, the original aim was changed from the impact of integration of nursing practice and knowledge to a larger focus on other role-players and their interactions. A literature review showed that there were no similar anthropological studies, particularly in South Africa, on a facilitated process of this kind.

Thick description provides a detailed description of participants' beliefs and behaviours interlaced with the broader (historical) context and the context in which these beliefs and behaviours occur. In writing up this study, I do not just present the participants' view (emic or insider perspective) but relate it to my analytical perspective (etic or outsider perspective) (Green and Thorogood, 2006). I do this by engaging with different concepts as I write about what I observed about the participants' perspective. These concepts will be unpacked as they emerge within the different chapters and include space, patronage, and trust. These concepts serve different purposes. Space is used to explain an observation not covered by the main framework of dominance and resistance (Chapter 3). Patronage is used to challenge the main framework and trust is an acknowledgement of the larger project this study was part of. The writing and analysis

are a product of what Green and Thorogood (2006 p. 61) call: “the tension between an etic and an emic perspective [which] drives ethnographic analysis.”

My own experience is central to this ethnography. Partly because I was asked to play an active role in the process of integration, reflexive awareness is important if an active role is taken (Parr, 2002) (see also section 2.7). I also believe that acknowledging the influence of my own background is pivotal in understanding the choices I made in research approach, design and analysis. As Agar (1980 p.15) points out: “the ethnographer’s background is the initial framework against which similarities and difference of in the studied group are assessed”. This quote highlights the importance of considering my own background as a researcher. For this reason section 2.7 will explain my strong focus on race inequalities in this thesis. Where appropriate and needed in this thesis, I reflect on my own background and my active role in the pilot project.

2.3 Research design



The research design adopted was flexible as is usual in qualitative studies and especially in ethnographies (Green and Thorogood, 2006). Initially I conducted a literature review to support the research proposal and gain an understanding of integration, and attended meetings related to the integration. As I collected data and analysed, I designed new tools to explore new and emerging avenues of inquiry. Field notes and a fieldwork diary were kept throughout the process. The sections below will provide an overview of these tools and has been divided into three sections: literature review, facilitated project and community.

Literature review

The literature review occurred in three distinct phases: South Africa 1999- 2003, one during the first period of writing in 2003 and one in the last two years 2010-2011.

South Africa 1999-2003

During this time I wrote the research proposal and searched for literature to help me focus my thoughts during fieldwork. The relatively restricted access to the internet at this time is reflected in the type of review:

- Catalogue search at the University of Cape Town library.
- Catalogue search at specialist libraries at the University of Leiden, Leiden, Netherlands: and the Africa Study Centre Gender Library, Leiden, Netherlands.
- Catalogue search at the Social Sciences Library, University of Amsterdam, Amsterdam, Netherlands.

Keywords included: integration, primary health care, Paradise Park, community participation, folk/traditional medicine. I also conducted focused searches for seminal works in anthropology, including by Foucault and Bourdieu.

Project-related literature was obtained from the SAHA office in Cape Town. Literature (particularly on trust) was shared among the researchers involved in the Administration of South Africa Project on a regular basis via email or handouts at the annual meetings. Grey literature was obtained from a catalogue search at the Simon's Town Museum, Cape Town, and provided information on Paradise Park during the forced removals of the Apartheid era.

Systematic searches also were conducted at the offices of the main newspapers in Cape Town: *The Argus* and the *Cape Times*. Articles were gathered to gain insight into how Paradise Park had been reported on in the past and during the pilot project. Similarly, I recorded two television documentaries related to Paradise Park:

- *Strong Enough* an ETV Documentary from 2001 relating the story of women from Paradise Park employed in the fishing industry.
- *Waiting to go Home* an ETV Documentary from 2001 focusing on forced removals and restitution in the greater Cape Town area.

Literature review 2003

During this first period of writing I had access to the online library of the University of Liverpool, Liverpool, UK, and I made several visits to the libraries in Leiden and Amsterdam mentioned above. In this period I also visited WHO in Geneva, Switzerland, to conduct a systematic search at their library using the keywords mentioned above. I was fortunate also to be given access to a personal library of a WHO staff member involved in research on integration.

Literature review 2010-2011

My literature review became more systematic during this time and I had access to the library at the University of Leeds, Leeds, UK. I conducted systematic keyword searches in bibliographic databases such as PubMed. An example of my search on community participation is given below:



Table 1 - Example of literature review search strategy

	Keywords	Including/excluding	Hits
1	(communi* adj2 (particip* or involv* or input or based or partnership* or engag*))		
2	South Africa		
		1+2	540
3	(communi* adj2 (particip* or involv* or input or partnership* or engag*))		
		2+3	187

Due to the small evidence base, searches for some topics resulted in few hits being returned. Therefore, I expanded my search to the following sources:

- ScienceDirect.com
- Jstor.com
- Google Scholar
- UCite
- Reference lists from relevant postgraduate teaching sessions

Inclusion and exclusion criteria

- Material in English and Afrikaans was included.
- Material on integration of health services in South Africa from the White Paper until the present (2012) was included.
- Material on the history of Paradise Park from the proclamation of the Forced Removals Act was included.
- Material on PHC from inception at Alma Ata until the present (2012) was included.
- Material on vertical integration was mostly excluded as the type of integration in the pilot project was meant to be comprehensive.

Facilitated project

I started off my research at the clinic and day hospital by spending at least one day with each staff member as part of an official observation of work patterns and gaining understanding of client pathways at the start of the facilitated project (end of 1999). I felt this would make staff members see that I was treating everyone equally and it also allowed individual staff members to get to know me and become used to my presence.

Participant observation is the mainstay of anthropological research (Barnard, 1988, 2011, Green and Thorogood, 2006) and I visited and participated for once or twice a week during most of the research period. My visits could be part of a day or a whole day depending on what seemed most appropriate. For example on some days it was possible to work at reception and do some filing while on other days staff were too busy or absent to allow me to get involved. On participant observation days I conducted numerous informal interviews as appropriate in the tearoom, waiting room and treatment rooms.

Semi-structured interviews were carried out with all staff members at the start, during and at the end of the process of integration. These interviews had the advantage of

providing some structure to my research design and show staff, managers and the facilitator this structure. At the middle set of interviews, I employed cognitive mapping of the community and the clinic and day hospital. I had been at the clinic and day hospital for about a year at this time (end of 2000, beginning 2001) and wanted to uncover subjective beliefs about their colleagues and the community as this seemed an emerging topic (Eden, 1992).

For the managers in this project, I conducted interviews with the area managers but did not manage to do so with the managers at middle and higher levels. Green and Thorogood (2006) highlight the problems associated with elite interviewing which I experienced with the managers. The area managers seemed to be speaking for their organisation rather than giving me their own opinions. Instead it was necessary and more useful to depend on observation during meetings to try and uncover beliefs and observe behaviours.

I participated at integration events which included staff meetings, management meetings, and district planning meetings for all staff from the district. My level of participation varied from observing to co-facilitating. This will be highlighted where these events are discussed in the thesis.

Various documents were consulted including health-related policy documents from the national, provincial and local government, project documents produced by SAHA, and relevant newspaper articles.

Community

Patients visiting the clinic and day hospital were interviewed informally on observation days. I initially hoped that this would provide me an insight into how the services were perceived and how the integration was seen and give an initial introduction into the community. This was, however, not the case. The community did not know about the

integration and I slowly realised that the community had varying different areas which I was not able to see clearly represented while staying inside the building of the clinic and day hospital. The informal interviews did not naturally lead to other research outside. During the first years 1999-2001 I was also very much occupied with the pilot project and it was only after the pilot project officially finished that I could consider venturing out of the clinic and day hospital.

I realised that I needed to devise a different way to introduce myself into the community and start to understand what they were experiencing. I designed a strategy to explore the community in 2002. This included the search at the Simon's Town Museum archive and the newspapers outlined above under literature review. To research the community I chose semi-structured interviews as these would not only allow me to ask about issues I had already picked up on, such as crime and forced removals, but also allow me to explore new themes which I wanted to know about, such as health seeking behaviour. Since this was exploratory research, I chose convenience sampling. I knew the community was divided into ten historically distinctive areas. To ensure I would be able to start to see if there were differences between these different areas, I decided to visit ten houses in each area during the day time (see ethics, section 2.6) and interview the person at home at that time. I chose an Afrikaans-speaking research assistant familiar with the community to come with me (see the sections on research assistants and on ethics section 2.6). This research took place between March and July, 2002.

My initial expectation was that I would follow up on this community research with some more in-depth work. Instead, apart from the research having to come to an end due to financial and personal reasons, key respondents were identified. As I went through the 5 months of research, participants would highlight people and organisations to me, who, in their opinion, could give me a better insight into the community. I followed this up by conducting in-depth interviews, between March and September, 2002, with key respondents including private doctors, other researchers, crèche owners, church leaders, managers of community organisations, school teachers, social workers,

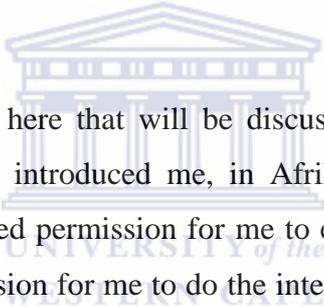
and people generally identified as active in the community, including those working with indigenous medicine, working with children or in organising sports activities.

As part of my active role in the facilitated process, I was asked by the staff of the clinic and day hospital, to conduct a client-satisfaction survey. Such surveys seemed to be fashionable in the health services at the time which was probably one of the reasons why they asked me to do one. It did not seem to clash with my research design and fitted in well with my active role in the facilitated process. As Russell Barnard (1988) points out that “there is no real conflict between ethnography and survey research” and he highlights its usefulness in getting acquainted with the patients. This is a recognised goal of surveys along with adding breadth to ethnographic research (Barnard, 1988, 2011). Whitehead (2002) points out, the common misunderstanding related to the classic division between qualitative and quantitative methods as ethnography is more than simply a qualitative method. Besides being useful in getting to know the patients, I thought that a survey and the report it could produce would be well received by the managers. They were, at the introduction of my study, sceptical about qualitative methodology and including a survey traditionally seen as a quantitative method, this made them feel more receptive towards the rest of my research. In reality this exercise was more a set of exit interviews due to limitations of time and resources. I always planned to make this part of the project much bigger with more follow-up. However, it really was a survey in name only. I have retained the name survey as this was how it was presented to the managers and staff. A questionnaire was designed with closed and open ended questions, translated into Afrikaans and administered face to face. This method was chosen due to high illiteracy in the community. Questions covered general information about age, number of children, location and use of the clinic and day hospital. This was followed with questions about the facilities, reception, staff, and pharmacy. An Afrikaans-speaking research assistant from the University of the Western Cape was employed to conduct the survey. Convenience sampling was used by targeting patients visiting the clinic and day hospital over 2 consecutive days and 35 patients were interviewed in April, 2001. Convenience sampling was chosen because it

would allow for the inclusion of any patients during clinic and day hospital opening hours. The survey was conducted over only 2 days due to budget constraints.

Research assistants: recruitment and training

Two research assistants were used during the community part of the research. Both were selected for their ability to speak Afrikaans. This was done for two reasons. First, although I speak Dutch and understand Afrikaans perfectly, my ability to speak it is limited. Second, my experience at Paradise Park showed me that speaking English had some negative connotations (see Chapter 6). For the client-satisfaction survey I wanted the questionnaire to be administered in Afrikaans to ensure a good response rate and franker answers.



There are some ethical issues here that will be discussed below (see section 2.6 on ethics). The research assistant introduced me, in Afrikaans, to the person at home, explained the research and asked permission for me to enter and conduct an interview. He would then also ask permission for me to do the interview in English but explaining that the participant was free to speak in Afrikaans as I would understand this. If the participant was female, the research assistant would leave the house and wait outside. If the participant was male, the research assistant would sit in the same room but as far away as possible with his body angled sideways to prevent intrusion.

In terms of training, the research assistant for the client-satisfaction survey was a PhD student from the University of the Western Cape. She was well trained in research methods and ethics and had administered questionnaires before. We discussed the survey design, the questions, the translation and the administration beforehand.

For the research assistant for the community research, the introduction was discussed beforehand and the research assistant was made aware of the aim of the research and

any ethical issues. The different choices for male or female participants were suggested by him and we discussed how he could seat himself to limit intrusion.

Both research assistants were paid for their time. Remuneration was set out by the University of the Western Cape.

2.4 Analysis

As Green and Thorogood (2006) point out analysis, process and tools, have traditionally received less attention in anthropology. Although the habit of clearly outlining analysis is now better established, it is very difficult to present a linear and structured list of tools (Green and Thorogood, 2006). As highlighted at the start of this chapter, it is the tension between emic and etic that drives the analysis in an ethnographic study (see section 2.2 on research approach). I will highlight my methods of analysis in as much detail as possible. Analysis is an ongoing process throughout the research and I shifted between theoretical frameworks and concepts including those related to nursing knowledge and practice, as highlighted under section 2.2, before settling on the ones used in this thesis.

I used thematic analysis for most of my data. For example I used such analysis to search in particular around dominance and resistance. Applying codes developed from the dominance and resistance strategies allowed me to see if this framework could be systematically applied. Applying codes related to dominance and resistance strategies allowed me to highlight where, when and between whom these strategies were occurring, whether they were occurring in a structured manner and if there were any incidences of negative evidence. The incidences of negative evidence could then be used to challenge my ideas and deepen the analysis during writing up. The discussion around patronage in Chapter 5 is an example of this.

For the client-satisfaction survey translation of the data was needed from Afrikaans into English, which was done with the research assistant. We translated and back-translated

and spend time on considering particular Afrikaans expressions. In some cases, these were retained to ensure the voice of the participant was preserved. As highlighted in section 2.3, the survey was partly used for presentation to managers who might feel more sympathetic to what they would perceive as a more quantitative presentation of data. The data were simply presented in percentages despite the fact that there could be no claim of generalizability from the survey. Similarly the community research was at times presented to managers in percentages. Some of these results have been retained in this report where they, in some way, reflect the presentation of the client-satisfaction survey or the community research.

2.5 Dissemination

Preliminary findings were disseminated at four conferences between 2000 and 2002 - the Anthropological Association of Southern Africa conference in 2000, the Generations and Continuity: Celebrating Ronne Frankenberg's Life and Work conference in 2000, the Medical Anthropology At Home conference in 2001, and the Gender, Reproductive Health and Populations Policies Project conference in 2002.

The Medical Anthropology At Home conference presentation was written up as an article and published in *Antropologia Medica* in 2002 (Parr, 2002).

In 2006, I was asked to present at the University of Cape Town/University of the Western Cape monthly anthropology seminar.

2.6 Ethical considerations

At the start of this research, approval was sought from the University of the Western Cape Senate. Ethical approval was part of the research approval process; however, no

specific sections on ethical approval needed to be completed at the time. Some of my thoughts on ethics are thus retrospective.

Participants were aware of my presence and what I was doing. My field notes and diary were kept private. This is in accordance with the two key principles for participant observation formulated by recent Association of Social Anthropologists (ASA) guidelines (ASA, 2011).

I will address three areas which are particularly relevant to this research in more detail; consent, anonymity and confidentiality, and protection of the researcher.

Consent

After receiving approval from the University of the Western Cape to conduct this research, a letter was provided by the head of department of Sociology and Anthropology. This letter was presented to the managers of the provincial and local departments of health in the Western Cape; I was asked to attend a management meeting to further explain my research and I received permission to proceed. This gave me permission to do research related to the integration project in the Western Cape.

Once at the clinic and day hospital, I was introduced as a researcher by the facilitator, and as I proceeded to observe at the clinic and day hospital. I took care to answer any questions and explain my research before taking on any more formal tasks such as interviews. Consent was obtained orally and on more than one occasion as the research was ongoing and I fostered close relationships with most of the staff. This is in line with ASA guidelines (ASA, 2011).

For the client-satisfaction survey, patients were asked if they wanted to take part in the survey and were taken to a private room within the clinic/day hospital building. Consent needed to be given immediately as the patients were caught at the clinic/day-hospital as

part of convenience sampling. (See the anonymity and power relationships sections for further discussion).

For the community research, the participants were asked to take part by the research assistant and they were interviewed in their home.

Anonymity and confidentiality

For the client-satisfaction survey and the community research, participants were told they would remain anonymous. For both maintaining anonymity might have been difficult to properly enforce as I could be easily be observed organising elements of the survey and going around in the community. For the client-satisfaction survey, in the clinic/day-hospital building, there could have been the risk attached of being identified, with negative feedback. The names of those taking part were however, not known to me or the research assistant and there was no link between the survey data and the participants. We did not need names to recruit participants, we did not need them for the survey and we were not planning a follow-up which limited the risk to participants.

For the community research, the risk was seen to be low as no directly sensitive questions were asked and participants were told they did not have to answer any of the questions asked. The homes visited were only known to me and my research assistant. Names were used to ease the interviews but not linked to data collected. Numbers were used during note-taking in interviews and during analysis. The linking documents were kept in a secure place separate from the data.

For the report, all names were changed. Similarly for the integration-related research, all names were changed. At the start of this thesis, the following statement can be found:

Please be advised that the names and/or identity of everyone involved in the project have been changed. This includes the names of the community and the

NGO involved in the project. This is in accordance to the requirements of ethical approval.

Protection of researcher

My work at the clinic and day hospital exposed me to communicable diseases and treatment situations including sharp objects. I ensured my vaccinations were up to date and I visited my doctor at the start and end of the research. I discussed my research with my doctor and we discussed any health risks including exposure to tuberculosis. In terms of working in treatments situations, I followed the instructions of staff and never got involved in the treatment of patients.

Paradise Park is a high-crime area particularly at night. For my own protection I only conducted research during the day. This was also why I chose a male research assistant with some standing in the community. It turned out to be necessary as I was threatened in a more isolated street at the top of the township. The research assistant ensured I could safely exit. I chose to conduct the community research in people's homes to help them feel more comfortable and the research assistant helped me do this safely.

Power relationships

Several power relationships might have played a role and need to be acknowledged:

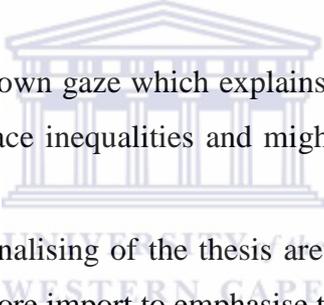
- After receiving approval from the local and provincial authorities, it might have felt very difficult to not take part in my research as a member of staff.
- Managers clearly felt in a more powerful relationship to me and some avoided interviews while others gave me expected answers.
- It might have been difficult for patients to say no to take part in the client-satisfaction survey, considering that they were asked while attending their health service.
- It might have been difficult for participants in the community research to say no to my research assistant who had high standing in the community.

2.7 Limitations

Limitations have been acknowledged and discussed in the text. These limitations include:

- My dislike for the pharmacist (section 4.9).
- The negotiations between the facilitator and the managers that happened in my absence (Chapter 5).
- Not asking explicitly about managers' backgrounds (section 5.2).
- Not making my own detailed notes for the first workshop (section 6.3).

Other limitations that need to be acknowledged are my gaze, the time frame, the focus and the larger project:

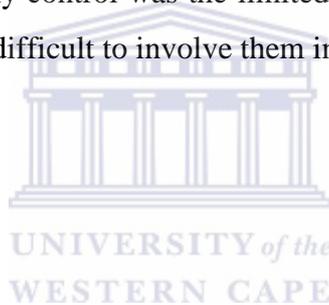
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- Chapter 3 explores my own gaze which explains why the aim of the thesis is in particular focused on race inequalities and might ignore, to some extent, other dimensions.
 - The research and the finalising of the thesis are fairly far apart, over 10 years. This entails it is even more important to emphasise that this thesis should be seen as a study of one place at one time. This also entails that literature on integration was mainly only applicable if it was published before or during this time. More recent debates have been included at a limited level.
 - During analysis and writing up the data developed and evolved. The topic and focus moved away from the one originally envisioned in the research proposal in 1999. The title of this thesis, inherited from this time and attached to the thesis in 1999 through the approval processes, could be more focused.
 - Not engaging with the findings of the other two researchers of the larger project, or in any great length with the findings of the larger project. This is due to the different focus my research took on.

In terms of the methodology, the limitations are the following issues. First regarding the research in the community, convenience sampling might be useful to explore the

community but it does limit who is included. In this case, day-time interviewing would miss out those people who are generally there in the evening or weekend for example. As I was accompanied by a research assistant with high standing in the community, this might have influenced what I was told. Participants might have wanted to show a certain side of the community which they thought this man would approve of because of his high standing in the community.

Second, the survey used face-to-face interviewing which takes a long time and meant that only a few people were included. Thus the survey was more like exit interviews and should not really be called a survey.

Third, an element not under my control was the limited community involvement in the pilot project. This did make it difficult to involve them in the analysis.



Chapter 3 - Integration in context: dominance and resistance

3.1 Introduction

As stated in Chapter 1, the research presented in the thesis is part of a larger project: the Administration South Africa Project. This project's strong focus on trust included considering to what extent people trust public institutions such as health services. In South Africa, distrust is ingrained from the Apartheid era and after the 1994 democratic elections the new government had much to prove to improve trust. Trust, as Bak and Askvik (2005) highlight in the book from the project, is needed for relationships of dependency and cooperation, as is needed in the health sector between patients and health professionals. Cooperation becomes important particularly not only from staff members who take part in changing the health system but also from community members in the various acts of participation in health. Trust is undermined by integration processes that are incomplete. The history of distrust in South Africa is of the utmost importance in understanding integration and the manner in which it works. I believe integration processes cannot be fully understood without appreciation of their context, a concept I offer in the thesis. This chapter derives from literature review and my own ethnographic research in the community.

I have chosen Scott's (1990) dominance and resistance theoretical framework for the thesis. South Africa's history of legislated relationships of power lends itself to explore the concepts of dominance and resistance. Choosing this framework first came to mind when a woman spoke up during a Healthy Cities meeting. She reminded me of Scott's description of Mrs Poyser and the hidden transcript (see Chapter 6). This incident was a prime example of how open resistance still is considered too dangerous or impossible to voice. The repercussions might not be in the form of violence, as occurred in the past, but in other forms (such as withdrawal of services) and the danger obviously is felt. Resistance by staff is also mentioned in the project's documentation as a major challenge.

As will be shown, Scott's framework proved very useful in understanding staff responses in the integration pilot project. The framework was then applied to the responses of managers and here also its usefulness became apparent. However, during analysis, I found that people's actions were less straightforward than the framework perhaps implies. Ortner's (1995) critique then provided an impetus for strengthening Scott's framework. Ortner stated that Scott's framework presents a binary view of power and does not account for other aspects of social life. Given the South African context, I could see acts of dominance and resistance needed considering with reference to (particularly) historical determinants. With this understanding I designed a framework to incorporate the influences around dominance and resistance strategies. The framework is intended to bring understanding to dominance and resistance in this particular facilitated integration project. However, it should be possible for the framework to be adapted to understand other similar projects.



I will highlight two major influences on health and health interventions. The first is the historical context of Apartheid in South Africa which influences everything from political choices to day-to-day discussions about people. For the thesis I focus particularly on the history of Coloured people in general and Paradise Park in particular. This is because the project took place in a Coloured township and understanding the township's origins helps explain the community's interaction with health and health interventions. The second is the international arena of the development of PHC internationally and in South Africa in particular. This section will also include a discussion on nursing practice in South Africa as nurses were the focus point for change in the integration pilot project.

Completing the framework are two factors that are specific to this project. The first is the present context of Paradise Park. This section will focus on data I collected in Paradise Park and thus represents the context during the facilitated process between 1999 and 2003. The second and final factor is the facilitator. I have chosen to focus this section on myself as a co-facilitator in the project as Yvette, the main facilitator, will be discussed in Chapter 3 on planning.

This chapter discusses each of these factors to form the framework in which the analysis chapters (3, 4, 5, 6 and 7) should be understood. After describing the literature review methods, I will discuss dominance and resistance as the central theoretical concepts.

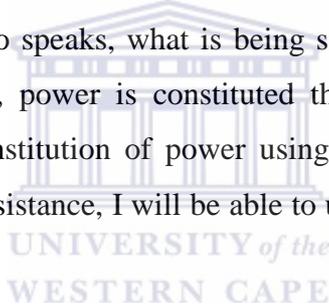
3.2 Dominance and resistance

“At its extremities, in its ultimate destinations, with those points where it becomes capillary ... in its more regional and local forms and institutions.”

Foucault (1980 p. 96) made the above statement about researching power. At the extremities are exactly where both power and resistance can be seen; where, at its ultimate destination, power becomes public during, for instance, project meetings at grassroots institutions. Some confusion exists among academics on whether Foucault's ideas leave space for resistance but I believe, along with Anderson (2008), that room for resistance exists, particularly since Foucault stated “where there is power, there is resistance” (Foucault, 1979 p. 95). To understand the acts of power and resistance, Foucault suggests it is necessary to explore how this power is employed. Scott's framework of dominance and resistance is useful for such exploration. Each visible use of power is seen as a symbol of dominance by Scott and reinforces hierarchy (Scott, 1990). Resistance can be concurrent, but Scott believes that what people really feel and think is mostly hidden but is always to some degree present in the public arena.

Resistance to change was reported in the documents reporting on former pilot projects (Owens, 1999a). What these reports omit, however, is how this resistance translates into actual responses. Resistance is not, generally, out in the open as will become clear later in the thesis. Resistance is, in this case, reactive: staff members respond to the facilitated process and the change of power relations in the integration process (as will be shown in section 6.4). However, the staff response is not reactive in terms of open revolts, rebellions which clearly show the agenda of the resistance. Instead it is much more subtle as the actual reasons for the resistance might not be publicised. Open

rebellion would be too dangerous as it could lead to redundancy and problems securing new employment in the same sector. In the history of South Africa, resistance to Apartheid was met with violence. This reaction is remembered by people and helps explain their hesitancy to openly voice their resistance. Resistance instead is enacted on a daily basis with numerous strategies. The concepts of public and hidden transcripts, as defined by Scott (1990), can provide good insight into the actual role each group played during the facilitated process. The hidden transcript, according to Scott, is always to some degree present in the public arena. It is usually presented in a more toned-down way and sanitised. By analysing the way in which the hidden transcript and the other strategies of resistance are present in the public arena, the real voices of the staff members can be uncovered. This is why I have found narrative analysis to be so useful to analyse the data. Through analysing the spoken and written words I was able to uncover the hidden meaning of those words. Narrative analysis allows this by considering systematically who speaks, what is being said and what is not being said. As Bourdieu (1991) suggests, power is constituted through language and everyday practice. By studying this constitution of power using narrative analysis and Scott's strategies of dominance and resistance, I will be able to uncover the power relationships in the integration project.



As my methodology included participant observation, I can illuminate partly the hidden transcript that is spoken outside the public arena (i.e. outside the gaze of management). However, I also need to analyse my own role, how I am perceived and which parts of the transcript might have been hidden also from me.

Scott (1990, 1985) defined the following strategies of dominance and resistance (Table 2). The definitions have been adapted to fit the case of the integration project presented here. After the analysis of the roles of managers and their strategies of dominance, it became clear that these strategies also display the characteristics of hidden transcripts.

Table 2 - Strategies of dominance and resistance

Strategies of dominance	
Affirmation	Events that are planned essentially as affirmations of a particular pattern of domination. These serve to magnify the awe in which managers are held.
Concealment	Controlling the public stage through propaganda and concealment of facts. Through this managers can create the appearance of what they would like the staff members to see.
Euphemization	Cosmetically beautify the aspects of power that cannot be denied by either masking them or sanitising them. Such tactics are particularly designed to obscure the use of coercion.
Stigmatisation	Stigmatise activities or individuals who seem to call those in power into question.
Unanimity	Create the appearance of unanimity among the managers and the appearance of consent among staff members.
Strategies of resistance	
Flattering	Flattering the self-image of the managers.
Hidden transcript	Staff members express their anger, discord, revenge, and self assertion when the managers are not present (ie outside the gaze of power).
Disguise/anonymity	Takes place in public view but is designed to have a double meaning or shield the identity of the actors.
Rupture	Making the hidden transcript public.

* (Scott, 1990).

Strategies of dominance can hide quite a number of underlying thoughts and feelings which show themselves in the public arena in a more sanitised and toned down manner. As will become clear from Chapter 5 on managers, Dr Lennox, the Provincial Administration manager, is the best example of this. However, Scott's framework does not consider that managers might act and suppress their real thoughts and feelings in this way. His framework suggests that acting (i.e. suppressing real emotions) is a necessity for those who are powerless. Having power and access to resources means not having to act (Scott, 1990 p. 29). Perhaps this acting strategy is an element of dominance and resistance in societies described by Scott, but I question whether this acting strategy operates in modern institutions. I will argue that the typical hierarchical bureaucracy of institutions means the head of a service does not have the same almost sovereign power as, say, a Malay landlord, as studied by Scott. Managers in the health service are always (to some degree) accountable to someone else, be it their own senior

manager in the DoH or trade unions. I was unable to understand either Dr Lennox or Dr Cabral's, the Municipal Administration manager, actions just by considering their strategies of dominance. As Chapter 5 will show, considering the socio economic and historical backgrounds and positions of both managers is needed to understand their choice of strategies of dominance.

This is one reason why I think Ortner (1995) is right in her critique of Scott's work. Scott's concepts are not simply binary i.e. dominance versus resistance. They do not exist simply as opposing powers, but they need to be seen in their context. Those parties involved in this integration project, including myself, are not a homogeneous group who resist or dominate. Ortner includes gender, age, and status as possible factors that can influence an individual. I agree, and I will show how these factors indeed influence individuals and, in some instances, their choice of strategy. However, the complex and holistic nature of reality means other social factors also influence dominance and resistance. These strategies would most likely not have been used without the particular history of dominance in South Africa and its influence on the present context of Paradise Park (see below), and if there had not been a pilot project which was designed in this manner with its background in the international health arena (see section 3.4 in this chapter and section 4.4 on planning).

Using dominance and resistance as a framework does require a discussion of power and how I define this concept in the thesis. The two distinctions in power made by Barnard and Spencer (1996) are intricately linked in the South African context. Power between groups was present in varying degrees during Apartheid, and still is. Considering power between an individual and a group is particularly useful when considering the facilitated integration project. For example, I will present the example of how nursing jobs were one of the few jobs open to Black and Coloured women. Positions of power, such as management positions, were not open to people from non-white backgrounds. Although the government was committed to creating a more equal society after the 1994 democratic elections, access to power does not change overnight. So, for example, a non-white person who reached the position of power of a doctor/manager during

Apartheid is significant for the analysis of the integration project even after the 1994 elections.

Power has to be based on something, and legitimised through something. Weber considers power through three different sources: legal/institutionalised, charismatic and traditional. I believe the concept of power is more flexible than this and more than one can exist for a person simultaneously. Sillander (2004, p.7) views authority as giving the “capacity to influence or authorize people’s actions or views”. This definition opens up authority to be viewed from the perspective of how it is achieved through different sources of authority, and the dynamic nature of authority.

The integration process developed from a process of policy development, based on international guidelines and led by a democratic government. I will show how this process was backed undoubtedly by legal/institutionalised authority and the managers represented the legal authorities of the municipal and provincial government. However, each of those parties exerting power have different sources of power. The next chapters will show, for example, that Dr Cabral drew on both legal and charismatic sources of power whereas Mrs Theron, the nurse who unofficially came to be in charge of the clinic, called on achieved status for her power. The focus on capacity in Sillander’s (2004) definition allows for shifts in authority. The introduction of a district health system in the integration process shows rapidly shifted authority from two administrations to only one. Sillander’s definition is more of use for complex societies and modern bureaucratic institutions such as health services.

However, as discussed in the introduction of this chapter, the concepts of dominance and resistance cannot be understood fully without considering the other elements of my framework. These elements are discussed next.

3.3 Historical context

This section will discuss briefly the history, terminology, and the social and geographical segregation, prominent themes in the formation of South African society, which still impact on today's Coloured township communities. The background presented here provides an understanding of how the present day Paradise Park was formed and shaped. First, the historical setting of the greater Cape Town area is described, forming the basis of the construction of separate identities, and living areas. The second and third sections focus on terminology and social and geographical segregation respectively. These sections set the scene for the last section, which describes the origins of Paradise Park.

The economic and spatial segregation initiated with colonisation and established with Apartheid still impacts on South African society. The elections in 1994 ended the formal restrictions on access to labour, education and public services (Jensen, 2001). However in reality geographical segregation persists and the stereotypes attached to each colour identity are reproduced every day in government, media, education and daily informal discourse (Shami, 1999, Reddy, 2001, Jeppie, 2001, Erasmus, 2001). This was certainly the case at the time of the pilot project and might well be the case at present. It is precisely because of the continued segregation and the on-going reproduction of constructed identities that a picture needs to be painted of the mainly Coloured township served by the Health Centre run partly by Coloured nurses involved in the pilot integration project.

The colonial origins of racialism¹

From the 17th century onwards, the histories of settlers and original inhabitants in the Cape area became intertwined. The permanent settlement by the Dutch East India

¹ Historical facts courtesy of Readers Digest Association South Africa OAKES, D. (1989) Readers Digest history of South Africa: the real story. Readers Digest Association South Africa..

Company (VOC) in 1651 led to increased trade with the Khoisan people and with the inevitable arrival of more settlers a struggle over land use soon ensued. The arrival of the Boers resulted in more slaves being introduced mostly from Madagascar, India, Ceylon, Malaya and Indonesia. More settlers arrived when the French Huguenots fled to the Cape after the Edict of Nantes of 1685.

No women from the countries of origin were present during the first 75 years of the settlement. Throughout this time numerous sexual encounters occurred between settlers, slaves and Khoisan women (Giliomee, 2003, Hendricks, 2001). Some of these relationships resulted in marriages although settlers preferred wives closely resembling White women; namely, Asian women and women of mixed descent (Giliomee, 2003). The Coloured population originated from this melting pot of people and its imbedded power relations. A remarkable range of ethnic origins originated from these relationships between settlers and slaves and Khoisan (Western, 1996).

Power relations established from the beginning of the settlement were closely related to colour. The burghers (settlers) were all White and born Christians whereas all the slaves and Khoikhoi servants were of low status and brown or black. Right away, a correlation between colour and status was established. However, a middle class also existed, consisting of White, Black and Coloured people who were neither slaves nor burghers (Giliomee, 2003). Besides the correlation between colour and social status, colour stereotyping was established very early. Western (1996, p.15) refers to Jan van Riebeeck (1619-1677) calling Khoikhoi “savages” and “lazy stinking people”. Additionally, terms expressing possession were used when discussing Coloured people; for example, *ons bruinmense* (literally, our brown people) (Western, 1996).

After colonisation, the next major change in the history of the Cape came with the arrival of the British (1795), the subsequent Boer War (BWI 1880-1881) and emancipation of the slaves (1808). The British promised to bring improvements in rights and social status for Coloured people. These hopes were shattered quickly after the British victory in the second Boer War (BWII 1899-1902), as status and access

based on colour remained basically unchanged (Western, 1996, Giliomee, 2003) (Hendricks, 2001). The Boer Wars more clearly etched the differences between Black, Coloured and White (Giliomee, 2003). The emancipation did change the position of Coloured people, albeit on paper only. Slavery was replaced by an exploitative labour system that very closely resembled the abolished slave system (Western, 1996). One positive change was that schooling was established by missions for Coloured children, and by the government for White children (Western, 1996).

In 1853 the Cape gained a degree of self-government based on a constitution allowing access to political influence to everyone equally, on paper. However, in reality, the government remained under the control of affluent White men (Western, 1996). Coloured people remained poor and had low status. On paper, Coloured people had access to jobs, schooling and housing. In reality, their wages remained lower, access to training and schooling continued to be minimal and property was unattainable (Giliomee, 2003).

The Verdrag van Vereeniging (Peace of Vereeniging) ended the second Boer War and marked the emergence of the first nationalist organisation, which led to the establishment of the Unie van Zuid Afrika (Union of South Africa). Parliamentary acts were passed that curtailed job opportunities and choices of living space for Black and Coloured people. Gradually the existing differences between White, Black and Coloured were institutionalised in parliamentary acts and state institutions (Jensen, 2001). Additionally, government and public discourse reinforced the idea that Black and Coloured people were different and inferior (Shami, 1999, Erasmus, 2001, Jeppie, 2001, Reddy, 2001). At the inception of the Apartheid concept by D.F. Malan (1874-1959) in 1948, actual segregation had long been occurring. Coloured people became more and more associated with poverty in, for instance, newspapers (Giliomee, 2003). Racial differences were being institutionalised by the establishment of Coloured institutions, space and jobs (Jensen, 2001).

The Apartheid concept named the process that had already started with the establishment of the settlement in the Cape. The idea and feeling that Black and Coloured people were of a different race, inferior, immoral, and obtuse came together in that one concept (Giliomee, 2003). The dominance of the pure and superior White race was exerted on all levels from micro-segregation on public transport to spatial and political segregation enforcing the psychological idea of segregation (Western, 1996). Apartheid therefore became the most extreme system of state intervention for a perceived subordinate group in a society (Giliomee, 2003).

The conceptualisation and discourses of racialism in South Africa have a long history originating in the colonial history of the Cape, nurtured by Dutch and British imperialism (Hendricks, 2001). This history of racialism informs present attitudes to Coloured people (Western, 1996). The construction of Coloured identity is one filled with ambiguity and power relations. Coloured people were not accepted as White but were excluded from being part of the Black population by conceptualisation, institutionalisation and discourse (Hendricks, 2001). As I will show, the construction of Coloured identity influences current thoughts and ideas on change, how change should come about and the roles taken by the community during change.

Gekleurden

The term Coloured first originated as a term of differentiation between White colonists and people of colour or *gekleurden*. Use of this term amalgamated free Blacks, Khoisan and people of mixed descent, whereas slaves were categorised separately (Western, 1996, Saunders and Southey, 1998). The term Coloured changed from a collective term to a separate term for people of mixed descent during the period of the emancipation, and later the industrial and mineral revolutions. The term Coloured, specifically for the Cape Coloured, became a way to assert their ancestry and colonial history. Especially in the Western Cape, people of mixed descent felt the need to distinguish themselves from the new arrivals drawn by the economic development in the Cape (Saunders and Southey, 1998, Giliomee, 2003).

Discourse on Coloured people in South Africa throughout history has focused around two themes: race mix and the residual identity. These are, respectively, themes about origins (pre-Apartheid discourse) and Apartheid constructions of identity (Erasmus, 2001). More recently the discourse has started to shift to understanding and acknowledging Coloured identity as an identity in its own right within a specific political and social context (Erasmus, 2001).

The theme of race mixing focuses on relationships in various forms between slaves, Khoisan and colonists, which produced the Coloured population. Slaves were brought to the Cape from, mainly, Madagascar, East Africa and the East Indies. Many examples of the residual identity theme were present during Apartheid. Coloured people were defined often by what they were not: a double negative according to Western (1996). For example, the Group Areas Act of 1950 defined Coloured people as “those who are both non-White and non-Black African” (Western, 1996, p.8). A commission (Union of South Africa, 1938) charged with defining the different racial groups found it complicated to define the Coloured group. The more conservative part of the commission developed this typology:

A person living in the Union of South Africa, who does not belong to one of its aboriginal races, but whom the presence of Coloured blood (especially due to descent from non-European brought to the Cape in the 17th or 18th century or from aboriginal Hottentot stock, and with the admixture of European or Bantu blood) can be established with reasonable certainty, a) from knowledge of the genealogy of the person during the last three or four generations; and/or b) by ordinary direct recognition of characteristic physical features ... by an observer familiar with these characteristics. (Jensen, 2001, p55)

The rest of the commission opposed this typology and consequently presented the following definition of this residual group, which closely resembles the definition employed by the Apartheid regime:

All persons not of unmixed European descent, or of unmixed Bantu descent, or of unmixed Asian descent unless ordinarily accepted as Coloured people. (Jensen, 2001, p.55)

However, as Hendricks and Erasmus (2001) argue, representations of Coloured identity as mixed or residual are not only tied into social, racial, and sexual politics but also embedded in power relations. These representations subscribe to the idea of the existence of separate races and racial purity. The Mixing discourse merely points to the formation of a population and ignores the processes that have constructed their identity. Both representations discount the formation of a specific and particular cultural formation acquired through shared experience. These representations presume that Black and White identities are somehow homogeneous and static (Erasmus, 2001). Moreover, these representations before and during the Apartheid era hinder the building of a national identity in the post-Apartheid era by the marginalisation and trivialisation of Coloured identity (Erasmus, 2001). Although Apartheid has formulated and solidified Coloured identity, Coloured identity has been produced and reproduced by the Coloured population from their inception till the present day (Erasmus, 2001).

In reality during Apartheid the Coloured racial category was very fluid. People who were able to pass for White would do so, as it brought better education, jobs and general opportunities (Western, 1996). The statement “by ordinary direct recognition of characteristic physical features by an observer familiar with these characteristics” as defined by the Wilcocks conservative member of the committee, became reality. A personal example is presented by a couple I met in Cape Town. Paul and Mandy told me their experiences of being racially re-classified in the 1980s. Paul, a British citizen, had married Mandy, a Coloured woman from Cape Town in Namibia. After the birth of their first child the whole family visited the government’s home office department in Cape Town. They had to be re-classified into one category as mixed families were forbidden. A group of Coloured people from the office were summoned. After observation, this group decided that all family members looked light enough to be re-classified as White. Paul said he was not surprised since the observers had been all very

dark skinned and his family must have looked very light in comparison (My field notes 1999).

Segregation

After the emancipation of the slaves in 1808, social segregation by colour in Cape Town was mainly directed by continuing unequal opportunities for people of colour. Although now formally free, the slaves still found themselves bound by contracts to their masters as servants. Criminal sanctions would result from breaking this contract through the Masters and Servants Ordinance of 1853 (Western, 1996). Coloured and Black people still received lower wages than other racial groups and their children only had access to the missionary schools. Politically, the new constitution did not differentiate between people of Colour and White people. The constitution established after the Cape Colony gained self-governance in 1853 stated that, in theory, all persons had equal access to political influence irrespective on their age, sex or income (Western, 1996). In reality, people of Colour found it difficult to gain political power due to unequal opportunities in education and labour. Additionally, when a person of Colour was in the position of gaining access to parliament the electoral law was adjusted to stop this person from entering; Rhodes², for instance, made such an adjustment in 1893 (Western, 1996). After emancipation, no legislation existed to prevent Coloured people from buying houses in any area. A market mechanism directed the buying and selling of houses, unlike the legislated segregation of the Transvaal and the Orange Free State. However, poverty would prevent Coloured and Black people from buying property. This poverty was compounded by the lack of education and restricted access to jobs in poorer areas (Western, 1996).

Geographical segregation for Black people was part of legislation long before Apartheid. Until 1890, most Black and Coloured people were housed on the premises of their employers. It was only when Black people were employed at Cape Town docks

² Rt Hon Cecil John Rhodes DCL (1853-1902) acting in his role as the 7th Prime Minister of the Cape Colony (1890-1896)

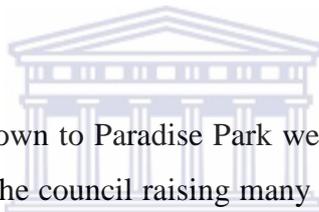
that the Black labourers were housed in special segregated compounds (Western, 1996). The townships originated two epidemics of disease; the bubonic plague of 1902 and the influenza epidemic of 1918 highlighted the conditions in the slums where mainly Black Africans lived. This was the start of, respectively, the government reserve of Ndabeni and the Model Township, Langa. Both were established away from the main Cape Town settlement. These two epidemics also instigated the Native Urban Areas Act of 1923, which restricted access to cities for Black people (Western, 1996). Over the following years the Black population increased due to urbanisation driven by industrialisation. The new arrivals were continually relocated to the townships. As Western (1996) notes, societal control was issued through the constant removal of people and control of space.

Similarly, the Coloured population was geographically segregated. Due to the increasing population pressure from 1900 onwards, Coloured people voluntarily moved to areas like Belgravia, Cleemoor in Athlone and Crawford. Others were moved, less voluntarily, to municipal housing estates in for example Maitland Garden Village, which was established in the 1920s (Western, 1996).

Separate spaces were established and legislated in the Land Act of 1913 and Native Urban Areas Act of 1923, which targeted Black farmers and all non-Whites respectively. This legislation established judicial spatial segregation long before the concept of Apartheid, incepted in 1948 by D.F. Malan, endorsed the idea that race groups should live separately and maintain their own identity. This was realised with the Group Areas Act in 1950. As stated above, the Cape Town municipal council initially refused to co-operate with the Act by delaying legislative procedures. The council delayed providing proposals for the establishment of group areas and refused to provide data on existing patterns of occupation and ownership unless subpoenaed (Western, 1996). In most cities the actual removals started soon after the passing of the Act. The first group area proclamations were made in Cape Town on 5th July 1957 (Western, 1996).

Paradise Park

Paradise Park was formed on 1st August, 1968, in the area then known as Slangkop, by residents from Simon's Town, Noordhoek, Glencairn, Sunnydale, Sunvalley, Ou Kaapse Weg area (Red Hill), Kalkbay and Kommetjie (Chotia, pre 1983, Maralack and Kriel, 1984). All areas are situated around the location of Paradise Park. Paradise Park is often, incorrectly, portrayed (e.g. Western's (1996) account) as the place to which only the Simon's Town Coloureds were removed forcibly. Actually, people from many areas were moved to Paradise Park, including tradesmen and municipal employees from Simon's Town, farmers from Noordhoek and fishermen from Glencairn. Some families owned their own homes and farms whereas others rented municipal houses. Some families made a good living while others lived on the breadline. A unique culture grew from this distinctive mixture of people from different social backgrounds and social classes.



The removals from Simon's Town to Paradise Park were the most prominent removals due to the other residents and the council raising many objections, which were reported in the media. Since Simon's Town was proclaimed a Whites-only area, Black and Indian people were also forced to move to other areas. When the Luyolo African location closed in 1965, between 1600 and 1700 Black people were moved to Guguletu (Willis, 1968). The Indian people in Simon's Town were moved to Rylands on the Cape Flats. Unlike the Coloured people who were still able to travel on public transport to Simon's Town, the Indian people who were moved to Rylands on the Cape Flats had difficulty bridging the 23 mile distance. It was virtually impossible to commute over that distance to keep their trade going, such as the shops with long opening hours on the dockyard (Willis, 1968).

An article originating from the Simon's Town museum reports that a meeting was held in 1956, before the first proposals came out, to "warn the Townsfolk of the coming of the Group Areas Act" (Simon's Town Museum, p.3). The article states that after this meeting people were outside crying and wondering: "What have we done wrong to be chased from the place where generations of our people have lived?" The first proposals

for the Group Areas Act concerning Simon's Town were made in 1959 but it took until the 1st of September, 1967, before the whole municipal area of Simon's Town was proclaimed a Whites-only area. The intermitting period included proposals of increasingly extreme zoning. The protests in Simon's Town are well documented and reflected in the many newspaper headlines. Proclamations cited the existing good relations between the races and disbelief at the proposals:

“Race relations excellent Simon's Town tells board zoning not wanted” (the *Cape Times*, 4/8/59)

“Simon's Town Mightor praises Coloured” (the *Cape Times*, 25/9/68)

“Coloured are stunned” (Simon's Town Museum document, 1/9/67)

One article speaks of the fear and uncertainty of the intermitting nine years:

“9 ½ - year story of suffering” (Simon's Town Museum document, no date)

Many articles came out with public statements of opposition:

“Simon's Town zoning opposed” (the *Cape Times*, 5/8/59)

“Simon's Town Council attacks group areas plans” (*The Argus*, 29/12/64)

“Objection to Simon's Town areas plan” (*The Argus*, 3/12/64)

“Simon's Town objects to Group Areas” (the *Cape Times*, 3/12/64)

The protests were later described as wanting to keep the current residential patterns. The residents felt the areas for different groups were already quite separate (Whisson, 1972). Two public enquiries were held in the intermitting period. Willis (1968, p.2-3) reported:

Not one person at either enquiry ... came forward to give evidence that he objected to his neighbours or traders. There was no objection from any section of the community or from any racial group against another.

In the area called Slangkop, later Paradise Park, removals happened in batches (Willis, 1968). Small groups of houses were built and then 30 to 40 families at a time were moved. However, the living conditions in Simon's Town worsened as no one was allowed to move without a permit and the municipality was unable to build sufficient new housing. Over-crowding emerged as a new problem (Willis, 1968).

In Simon's Town, 805 families (approximately 5.000 people) were on the removals list in 1968. The Group Areas Act stated removals could only take place one year after the date of proclamation, which in the case of Simon's Town was followed short of a month. According to the Act, residents should be given a three-month notice of their move. In reality, notice of only a few weeks was typical.

The exertion of power in the act of removals lies in the details of their execution. To start the removal residents had to sign a contract, pay one month's rent in advance (between 82 cents and R1.72, in 1968 terms), a ten-cent revenue stamp and a deposit of R6.00 if they chose to have electricity. For comparison, average wages varied between R50 and R180 per month (it must be noted that many people earned far less than R50) at that time. Finally residents were asked to sign a form stating their acceptance of the offered allotment or to:

... find alternative accommodation for their family and declare, further, that they do not hold the Department of Community Development or any other authority responsible for finding alternative accommodation, and they undertake to move from their present accommodation as soon as a removal notice has been served to them. (Willis, 1968, p.6-8)

The contract contained several regular conditions restricting sub-letting, building of extra structures and aerals. Additionally the contract stated some more imposing conditions such as the sandy ground having to be kept in a neat and tidy condition, no holes or nails might be put in the walls, and no additional washing lines might be put up. During the removal, families had to pay for their own transport. Animals could be taken along; however, chickens had to be eaten after arrival at the rate of one a week.

Only three shops were available for letting and to acquire one a “most formidable questionnaire” (Simon’s Town Museum document, no date) had to be completed. Most shopkeepers owned their former businesses whereas after removal they had to pay rent with no prospect of being allowed to buy their premises in the future (Willis, 1968). Public transport was arranged between Paradise Park and Simon’s Town albeit only three times a day with relatively expensive fares (Willis, 1968, Progressive Party, 1968).

The Black Sash³, local churches, mosques and other organisations opposed the removals. As the removals became a reality, a citizens Advice Office was established. Unfortunately, office staff lacked qualifications or training for many of the required work. Work varied from applications for priority housing to paralegal activities and from social work to psychology (Willis, 1968, Progressive Party, 1968). Willis was one of the people inspired to initiate and volunteer at the Advice Office. She states:

It was not good enough to defend and protest and then abandon those members of the family who were to have their very roots torn up for an unwanted human transplant to an unknown area, with all the attendant shock, misery, heartbreak, bewilderment, uncertainty and financial loss and expense it would entail. (Willis, 1968, p.3)

Neighbourhoods and families were broken up in the removals. The new areas were far from work, with a virtually non-existent public transport system and poor infrastructure. In Paradise Park, for example, many people lost their occupations, their land and houses

³ Saunders and Southey (1998 p.26) describe the Black Sash as: “An organisation of white women, originally the Women’s Defence of the Constitution League, founded in 1955 to propagate respect for the constitution at the time of the Coloured vote issue. Its members stood in silence in public places, carrying placards and wearing white dresses crossed by broad diagonal black sashes, a symbol of mourning for the government’s treatment of the constitution. While such picketing continued in subsequent decades, mainly on civil rights issues, the Sash’s most significant work in the 1970s and 1980s was carried out in its advice offices in urban centres, which tried to help Africans with such problems as influx control, unemployment, contracts, housing and pensions.” The South Africa History website (2012) states: “Black Sash has now shifted from being a protest organisation to being a professional one, still upholding the same principals of making submissions to government in shaping legislation and advising on welfare.”

(Willis, 1968, Whisson, 1972, Giliomee, 2003). The Paper for the Progressive Party (1968) wrote that 128.000 Coloured people were affected by removals in the Cape Town metropolitan area. The history of forced removals, and living in a new environment with neighbours from different backgrounds, required the rebuilding of lives, social and cultural structures including social class. Memories/history of this lived experience has been a central aspect in the identity formation of Coloured people in Paradise Park. (Field, 2001)

The choice of wording in the articles and newspapers at the time of the removals indicates the attitude held towards Coloured people and, more importantly the attitude Coloured people held towards themselves. The wordings reveal Coloured people being seen as serviceable, with suggestions of Coloured people being possessions and lacking responsibility. Serviceability is shown in the following quotes:

... serve the needs of the naval community and the townspeople, and if they were evicted. (the *Cape Times* 5/8/59)

There was little hope of their business being taken over by Europeans. (the *Cape Times*, 5/8/59)

... a great loss of revenue to the town. ("After the move" *The Cape Argus* 15/12/73)

They [Coloured people] feel they belong. They helped to build the town. (*The Cape Argus* 26/9/68, the *Cape Times*, 26/9/68)

The above quotes focus on how Coloured people provide a service to the community in building and maintaining it, and the impact of losing their service through removal. Suggestions of Coloured people as possessions and lacking responsibility can be found in the following quotes:

We, in Simon's Town, are proud of our so clean people and their desire to garden. (Willis, 1968, p.9)

A baby is expected anyway. (*The Cape Argus* 26/09/68)

As most families have on an average five children. (*The Cape Argus* 26/9/68, the *Cape Times*, 26/9/68)

These quotes show possession in the word “our” and the implied comparison that other Coloured people are not so clean. The references to family size can only imply that family planning is disapproved of in the Coloured community. I find the comment on gardening quite fascinating. Simon’s Town naval base was owned by the British until 1957, a decade prior to the removals. Gardening is a popular (some would say, obsessive) pastime among the English. One possibility is that the quote comes from someone with an English background who wants to suggest gardening is done by civilised persons.

Separation is another prominent issue in the newspaper reports. This issue of separation divides itself between the already existing separation and racial harmony. It also talks of the importance of the Coloured citizens to Simon’s town such as their part in building the town and their role in the Second World War:

Simon’s Town had for centuries enjoyed complete racial harmony and its inhabitants had voluntarily segregated themselves into White and non-White residential areas. (*The Cape Argus*, 29/12/64)

... his forebearers came to Simon’s Town more than 200 years ago. (*The Cape Argus*, 1/9/67)

... ex-servicemen during the Second World War ... (*The Cape Argus*, 1/9/67)

Most of these excerpts are from articles written by reporters quoting White residents who do not have to move. As stated above, the main gist of the articles is protest. The reasons for the protest (labour and loss of shops) are cited. However, more direct protests against the law also are evident:

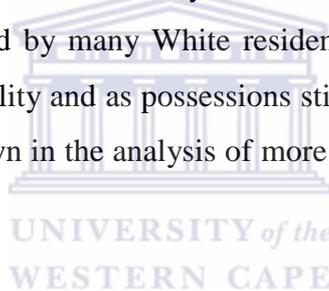
... a man likes to make up his own mind where to live, and not have it made up for him by a bureaucrat. (*the Cape Times*, 26/9/68)

As stated earlier, the paper from the Progressive Party offered the most critical voice during this time. Excerpts from this paper read:

It has been claimed by the government that there is no racial discrimination in the application of the Group Areas Act, since both Whites and non-Whites suffer. The fact remains, however, that comparatively few Whites are affected. (Progressive Party, 1968)

In many towns the entire built-up area has been allocated to the Whites, and non-Whites are being moved to undeveloped areas outside the towns, without any amenities they have hitherto enjoyed. (Progressive Party, 1968)

Although some reporters raise the real issues from the perspective of the Coloured citizens of forced removals, most newspaper articles focus on the loss suffered by the White residents who were not removed. The articles emphasise the existing separation and perceived race harmony existing before the removals. Coloured residents also repeated this existing separation and harmony. In fact this is still repeated by Paradise Park residents. The views held by many White residents towards Coloured people as serviceable, lacking responsibility and as possessions still existed during the time of the pilot project. This will be shown in the analysis of more recent media sources in section 3.5.



In summary, it is important to appreciate that identity and space were not constructed solely by Apartheid. Racialism finds its origins in the colonial history of the Cape and geographical segregation became law long before Apartheid. These constructions and realities are characterised by ambiguity and power relations, which still exist today.

Geographical segregation was used to exert control over a group of people. Additionally, the attention to detail in the execution of the removals supports this exertion of power. Paradise Park is one of the areas to which Coloured people were moved. It is made up of people from various areas in the Cape peninsula with varied social backgrounds. A common characteristic, perhaps, is that they all lost out in their old lives and in the choice of Group Area. This division influenced the meanings of space and place in the greater peninsula area, which will be discussed in section 3.5 on present context.

3.4 The international arena

A driving force for the Paradise Park integration pilot project was the developments in health and health care promoted in the international arena. This section discusses the origins of integration, PHC, the choice of selective versus comprehensive approaches, and the views on integration in South Africa after Apartheid. This section concludes by discussing nursing in South Africa and its particular history.

Integration

The issue of health-service integration came to the international agenda when WHO's executive board provided the foundation for the 1973 Alma-Ata conference (WHO, 1978) by concluding that a basic health strategy was needed and health should "no longer be isolated and defined solely within the health sector" (WHO, 1996). The Alma-Ata conference declaration viewed the future of health services in the co-ordination of all players including communities, families and the individual. The declaration emphasised that PHC would be the ideal approach to provide access to essential health care for all by the year 2000.

However, the global recession would make implementing this approach very difficult for poorer countries (WHO, 1996). Also, this comprehensive approach to health care was not accepted as the best way forward by all involved in the health sector. Especially during the 1980s, a very lively debate was held on the merits of selective versus comprehensive PHC. Walsh and Warren wrote in 1979 stating that comprehensive PHC was too idealistic and the selective approach was therefore preferable (Walsh and Warren, 1979). A selective approach to PHC entails health programmes which have been selected to improve the health status of an area at low cost through medical interventions and a fast transfer of technology executed by members of the medical profession (Rifkin and Walt, 1986). Newell (1988) adds that the comprehensive PHC approach inevitably leads to some programme to be put into action. Such a programme leads to listings of health problems, which leads to objectives, which leads to a selective

approach with vertical programmes. Here the critique from Atun et al. (2010) has to be noted; their systematic review concludes that selective versus comprehensive is a false dichotomy and that in reality there are no fully integrated or fully un-integrated programmes.

Rifkin and Walt (1986) make a strong case for the comprehensive approach to PHC, which they define as linking health status to developments in society at large. Interventions should then be accomplished through changes in social, political and economic processes. The authors identify four areas that planners should consider when choosing a selective or comprehensive approach to PHC:

- a) The difference between definitions of health. Selective PHC defines health as the absence of disease while comprehensive PHC defines it as total well-being.
- b) The importance of equity i.e. recognising and addressing poverty and resource distribution, which is an important aspect of comprehensive PHC.
- c) The call for a multi sectoral approach as part of comprehensive PHC. Environmental, social and economic aspects should be addressed as well as health aspects. The comprehensive approach calls for a unified approach to health.
- d) The importance of community involvement in health care in the comprehensive PHC approach.

Rifkin and Walt (1986) state that the views on these four areas determine a focus on programmes or processes i.e. selective or comprehensive PHC. However, Newell (1988) argues: does a choice for comprehensive PHC lead to actual comprehensive change processes? A government might choose comprehensive PHC as the ideal concept to lead the health sector into change, but how is it implemented once this choice has been made? Moreover, is the government assuming a level playing field and forgetting the context? A consequence of this assumption is that integration of the health system, an intervention identified by WHO as essentially informed from the bottom-up and community-based, is proposed for countries where “the basic social preconditions for success are lacking, or where community structures and resources are

inadequate to respond to such program goals” (Manderson and Whiteford, 2000, p.2). These authors add that the whole idea of “bottom-up and community-based” programmes is based on impossibilities. These policies are in essence always “predetermined and prioritised at the centre”. Additionally community-based interventions, which require community participation, are idealistic. The policy literature praises the perceived role of communities in the realisation of the policy but ignore the realities of those communities, which could make the participation of community members improbable and even impossible.

In South Africa, the comprehensive approach is generally accepted as the approach that will improve the health system. The South African government doubtlessly is guided by the demand for equality and equity promised in the elections, which includes within the health system. The proposed restructuring of the health system by the African National Congress-led government is in accordance with WHO’s PHC approach within a unitary decentralised national health system, a District Health System (DHS) (Pillay, 2001, Pillay et al., 2003). The definition for PHC provided by WHO reads as follows:

The PHC approach thus broadened the challenge of “integration” from that of bringing together tasks and functions within health services to mobilising health-related activities in other sectors, as well as the activities of families and communities, and linking them with health services.(WHO, 1996, p.2)

Key aspects of this approach are the development of comprehensive, equitable and holistic care through a combination of prevention, promotion and rehabilitation (WHO, 1996). Fundamental to the development of a DHS are equity, accessibility, emphasis on promotion and prevention, intersectoral action⁴, community involvement, decentralisation, integration of health programmes and integration of currently separate health activities (WHO, 1996).

⁴ Intersectoral action refers to the intersectoral components of a fully integrated DHS, which will combine to achieve the district health goals. This involves environmental, educational and social services. Moreover income-generating projects should be present, and primed for the local situation (WHO 1996, p.22-23).

Within the health system the district level is perceived to be in a position to combine co-ordinated planning from above and bottom-up. Also, the district will be able to organise community input for planning and implementation (WHO, 1996). The district hospital plays a central role as a support for referrals creating a complete functioning health system in one district (WHO, 1996). In 1986 WHO described the DHS by defining the district, a focus on health outside the Community Health Centres (CHCs) and the role of the facilitator in accomplishing the DHS. A DHS is described as follows:

A health system based on Primary Health Care is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, nongovernmental, private, or traditional. A district health system, therefore, consists of a large variety of interrelated elements that contribute to health in homes, schools, work places and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of primitive, preventive, curative and rehabilitative health activities. (WHO, 1996, p.20)

Although WHO emphasises that the creation of a DHS with integrated services should by no means be seen as a panacea, it seems the South African government regards it as such. The present government might have been swayed by the promises of integration to address the problems of fragmentation and inequality of the health services inherited from the former Apartheid government (Schierhout and Fonn, 1999). David McCoy from SAHA said as much, at the 1999 National Summit on Nursing, when he called DHS “a cure for the fragmented, inequitable and inefficient health system of the past, and the best system for delivering the PHC approach”.

Nursing practice in South Africa

Nursing knowledge and practice cannot be understood without reference to the history of South Africa and of nursing in South Africa. Nursing in other parts of the world has always had to deal with professional and class struggles. In South Africa issues of race and ethnicity have intersected with these struggles. Black women did not have access to nursing education until the turn of the 19th century and then only in limited numbers. Black women were employed mainly as supporting staff, taking on the domestic roles of nursing. The first hospital to train Black nurses was a mission hospital, Victoria Hospital, Wynberg, Cape Town (Digby and Sweet, 2002). Black women have dealt until recently with unequal pay, problems with promotions and separate education. Understandably, therefore, the hierarchy of nursing still reflects South Africa's history (Marks, 1994, Bloom and McIntyre, 1998, Jewkes et al., 1998).

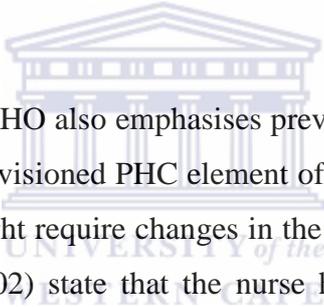
Historically, nursing has been a gendered profession. In society, the nurse and nursing are associated with women and women's work (Abbot and Wallace, 1990, Davies, 1995). These gender norms were used originally to legitimise nursing for women as the tasks performed by women in the home were similar to those of a nurse. However, using the ideologies of femininity to enable women to enter the workforce is also used to limit the work of nurses. Originally, nurses observed and reported and doctors diagnosed and prescribed (Gamarnikow, 1993, Marks, 1994). However, nurses in the CHCs often have additional tasks formerly reserved for doctors. In 1981 the law was changed to give nurses the right to perform tasks formerly associated with doctors. Now, nurses are observing, diagnosing and prescribing and referring if a doctor is unavailable (Marks, 1994). Searle and Pera (1999, p.37) describe the protocol for this situation:

When any registered nurse has perforce to perform acts that are customarily performed by medical practitioners and pharmacists, she does so as a nurse and performs a nursing function. She does so in order to meet the urgent needs of a patient who will suffer some harm if his immediate health need is not met. When she does so she must protect both herself and her patient by duly recording her actions for referral to a medical practitioner.

The phrases “perforce to perform” and in cases where the” patient is to suffer some harm” are open to interpretation, which leaves the nursing practice open to the risk of litigation. The protocol states that nursing practice is protected from this risk by recording the performed actions.

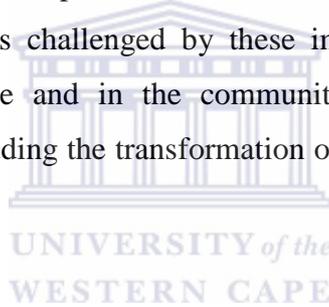
Transforming nursing practice

The transformation of the health-care system (as defined by WHO) entails a change in nursing knowledge and practice, in that all nurses can treat any patients and the end of specialisations. The new health system aims to have Clinical Nurse Practitioners (CNPs) running the CHCs, with doctors therefore based at hospitals. These changes will influence the hierarchy of knowledge and give new relevance to the legitimisation of knowledge.



Integration as formulated by WHO also emphasises prevention. The nurses will have an important role to play in the envisioned PHC element of community’s responsibility for their own health care. This might require changes in the relationship between nurse and patient. Digby and Sweet (2002) state that the nurse has a pivotal role in brokering change in a community. The authors discuss the role of the nurse in social change, facilitating interaction between different forms of medicine and aiding the patient to understand different health-care options (including traditional care). The biomedical sector, although this is now changing rapidly, has viewed traditional healers as endangering a patient’s health (Helman, 2000). The emphasis in South Africa’s training institutes (especially in mission hospitals) has been on the superiority of biomedical medicine and the need to substitute indigenous practices. Many training handbooks do not mention the other health system; for example, the manual for community nursing (Vlok, 2000) omits traditional healers, indigenous practices or beliefs. The manual does list a number of biomedically accredited counsellors, organisations, and support medical professions. Major changes in education would be needed to facilitate a radical change in perceptions and attitudes regarding traditional healing.

On the whole, the additional tasks for nurses of direct involvement and responsibility for education, information and health promotion in the community might prove to be unfeasible. This is because nurses already experience a high workload, poor working conditions, low pay, long and inflexible working hours and poor staff facilities (Jewkes et al., 1998). Clinics are generally understaffed and are short of equipment and drugs. Also, nurses' status and identity in public health services have been devalued. Although nursing education is now at the tertiary level, many nurses exit the public health services to enter the private health sector or seek overseas work opportunities to obtain better salaries, working hours and benefits. This migration has led to nurses defining, and being defined, as a powerless group. Despite the staff shortages and difficult working circumstances, nurses are able to do their job and do it well (Holmes and Gastaldo, 2002). Clients at public health services, however, report long waiting times and scolding nurses caused by the problems nurses encounter in their work (Jewkes et al., 1998). Nursing practice is challenged by these internal factors and by external factors e.g. violence at home and in the community (Jewkes et al., 1998). The implementation of policy including the transformation of the health system, adds to this load.



3.5 Present context

This section will focus on the present day situation in the Cape Peninsula. First, I will discuss the meaning of space and place in the Peninsula. This section will show how Apartheid has shaped the living spaces by using the natural geography. I also discuss the meaning of place I observed during the time I lived in South Africa. Section 3.3 on history discussed forced removals but it did not show how the removals consequently shaped the landscape with vast contrasts and meaning over the last three decades. Much could be written on this issue. However, instead I have chosen several prominent issues to be explained from my perspective rather than using the literature (as I was an active participant in this process). Second, I will present a picture of Paradise Park as I found it when I did my research in the community. I will focus on the social services, the

challenges people feel they face in the community and the manner in which the community is portrayed in the media.

A landscape of contrast and meaning

Cape Town is an area with many contrasts, like so much of South Africa. Table Mountain and the other mountains divide the Cape Peninsula in two. One side of the mountain has lush vegetation and the world-famous botanical gardens. The Indian Ocean is fairly gentle and warm. The other side of the mountain is windy, the lands are arid, and the Atlantic Ocean is wild and freezing. It is not a coincidence that the richer areas are on the lush side of the mountain and the townships have been placed, under forced removals, in the more arid and dangerous areas of the Cape Peninsula. As Kuper (2003) points out, South Africa is the most blatant example of Contested Space. Contested Space is redefined depending on the context in which it is used. The common denominators are always conflict and control. For the purpose of the thesis, I define Contested Space as the use of the landscape to control residence, economic opportunities, social spaces, access to amenities and mobility by a powerful minority who controlled the majority of resources during the Apartheid. In this section I will consider, from my point of view, what this Contested Space means for Cape Town. Paradise Park is situated on the windy side of the mountain. It is an isolated and barren area. The isolation is reinforced by the lack of public transport from Paradise Park. Most people who were moved there had to change their occupation. The farmers could not farm on this barren land and fisherman (and women) now faced grave peril when working at sea. Navy personnel were transported daily by Navy vehicles to and from Simon's Town on the good side of the mountain, while others lost their jobs due to the lack of public transportation. Forced removals put walls between groups of people - walls made of mountains resulting in isolation, worse living conditions and increased poverty for those on the bad side of the mountain. These same walls, that keep the poor in their place, allow the rich (the White) to live a life where they do not have to see poverty.

The meaning of place

Uniquely South African is the meanings attached to residency; that is, a person's suburb is perceived as making a statement about that person. For example, in Cape Town, the southern suburbs are traditionally White English while the northern suburbs are traditionally White Afrikaans and generally middle class. To state you are from the southern suburbs, which circle Table Mountain, will mean you are most likely White and ex-pat or of English descent. While areas such as Camps Bay and Clifton would indicate high income and upper-middle class. To take it one step further, a perceived difference exists between living in Observatory (like Yvette, the facilitator in the project described in the thesis) or Wynberg in the southern suburbs. If you live in Observatory, you are most likely working or studying at the university and you are a liberal. If you are from Wynberg you quite likely have a good income and a modern lifestyle. People might choose to live in a certain area that is perceived to have a higher social status, while settling for a smaller house. When I first arrived in Cape Town I lived in a flat in Wynberg which was perceived to be a very good area, giving me the social label of upwardly mobile. Then I moved to a large house in Plumstead, also in the southern suburbs, a relative step down the social ladder. Most people I encountered did not even know this was a southern suburb. I decided I would rather live in a large house than a cramped flat for a similar amount of money. However, this is not what most Capetonians would have done if given the choice and I found myself constantly having to explain it was a nice area despite it being so close to quite badly crime-ridden Coloured areas such as Lotus Rivier. No one quite understood why I would want to leave a clearly good area such as Wynberg for a less desirable area. These areas described, the southern suburbs, are suburbs with positive connotations but the reverse is also true (Western, 1996). Admitting you are a resident of Manenberg on the Cape flats, would likely make the listener turn pale and step back. Manenberg is known for its gang violence: a stigma for anyone stating they live there. One of my students did research in Manenberg. When she took some young people for a ride in her car, they found it hilarious to scare other motorists at traffic lights by loudly stating where they were from.

Therefore I considered my and Yvette's residences contrasted with those of the residents of Paradise Park. Yvette's house in Observatory was a large free-standing house with Cape colonial influences (i.e. a large porch, columns around the entrance and decorative gables). My house looked more like an English holiday bungalow with a low fence and gate, large garden, porch, two bedrooms and a garage. My house, unlike Yvette's, had bars on the windows. This is a common preventive measure against burglary in houses in South Africa. Similarly (although depending on the suburb), many properties have closed gates and high fences that cannot be seen over. Similar to most houses in the Southern suburbs, mine and Yvette's had good views of Table Mountain and its lush vegetation.

Contrast of place

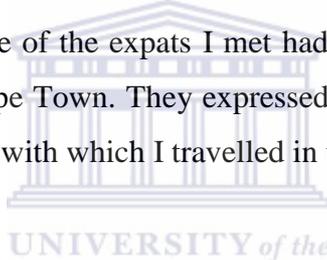
The contrast between rich and poor is evident in the Cape Peninsula landscape, including beyond the good and bad side of the mountain. The following example comes from Paradise Park. Entering and exiting Paradise Park by car is possible by only one road, a turnoff on the road from Noordhoek to Kommetjie. When residents of Paradise Park leave the site, often on foot, they walk down this road and get a good view of the Imhoff's Gift farm-stall on the land opposite the T-junction. For clarity, a farm stall in Cape Town usually denotes a large colonial farm house located on a piece of land (say, the size of three football fields). These farm-stalls usually sell local produce, plants and have a coffee shop and garden. Unreachable by public transport, most farm-stalls therefore are frequented mostly by tourists and South African's with both money and a car (i.e. White South Africans and expats). Imhoff's Gift's farm-stall contrasts starkly with the surrounding area. The farm-stall is surrounded by trees with welcoming shade on hot days, whereas Paradise Park is devoid of trees. The Imhoff Gift farmhouse stands alone on a large plot of land, whereas most Paradise Park houses are built closely together. The farm-stall sells expensive food items while many are poor in Paradise Park and struggle even to buy bread for their families.

Contrasts normalise

Colonialism and Apartheid have resulted in a large gap between rich and poor. Another architectural example is given by the beautiful malls where the rich (mostly White) shop, a drive of thirty minutes away from the poorest townships. It is surprising how quickly this contrast becomes normal and you stop seeing this contrast. I arrived in South Africa in 1997 from the Netherlands where contrasts exist but are less prominent. In 2001, I took a visiting professor on a tour of my research site, Paradise Park. I showed her the clinic and the day hospital, and drove her through the different areas: the dilapidated flats, the area with the newer houses, and the wild bush area where the Rastafarians (Rastas) live. We then toured Masipumele, a Black township with mostly huts made of corrugated iron which is situated on the same side of the mountain as Paradise Park. I then wanted to stop off for some groceries before dropping her off at her bed and breakfast accommodation. I drove us to the Constantia shopping mall, which is situated on the other side of the mountain in the southern suburbs. The mall contained a supermarket I usually visited after returning from working in Paradise Park. I liked it because the parking was easy, it was on the way to my house with easy access from the highway, and I found the coolness of the marble mall a welcome reprieve on a hot day. After parking, we walked through the automatic sliding doors and encountered exclusive boutiques on the left and a bookshop with a coffee shop on the right. The colour scheme of cream and red marble tiles and green trimmings on the walls, with large marble columns, made the mall appear rich and luxurious. The moment the professor entered the mall she stumbled and reached out to the wall. She wondered how this contrast could be possible: she was in a township with such poverty just a moment ago and yet she now entered such richness and luxury. She then questioned “Why I did not see it, and why did this not affect me?” The contrast did affect me when I first arrived, but over time it had become normal and less visible. For people who grow up in South Africa, assuming they have real exposure to townships (see the next section), such contrast must seem completely normal if they know no different.

Ignoring the contrast

Not only have many White people never known any different but this contrast can also be ignored easily. White people take their air-conditioned cars from their gated house, drive on good streets and highways to luxurious malls. The forced removals have ensured that the Coloured and Black poor live on the other side of the mountain and therefore are rarely seen in the full context of poverty by White people. These are the poor people who travel to and from town to work, walk in the heat for many kilometres and sit in over-capacity minibus taxis for long journeys. The poor are seen individually by the rich without the context of their families, their friendships, their loves and hardships, and in many cases without the abject poverty of huts made of drift wood and corrugated iron, the fear of natural disasters and the violence of the township. The rich look at them but never really have to see them, if they choose not to. Apartheid has allowed invisible walls to be constructed so that the White do not have to see the Black and Coloured population. None of the expats I met had even been in a township in all the years they had lived in Cape Town. They expressed fear and lack of understanding of my job and the relative ease with which I travelled in townships.



This is the social landscape for Paradise Park and its residents. Section 3.3 highlighted Paradise Park's origins and history. In the next section I will recount the stories collected during my fieldwork related to present-day Paradise Park. This section aims to describe and explain the background to the community in which this integration pilot project took place.

The Paradise Park community

We were 21 children. We lived on a farm with a river. We were happy children. When we were sick my father would make us herb drinks for infections, for the measles, to sleep lekker⁵. Father changed when we were moved here. He started

⁵ 'Lekker' is an Afrikaans word meaning 'good', 'well', 'nice'. It can be used to describe many things, such as feeling good, sleeping well, or good food.

drinking. He became a fisherman and a bricklayer. He never made us any herbs again. It changed a lot of people. (My field notes, April, 2002)

The data cited in this section originate from structured community research collected over five months in 2002. The aim was to gather opinions from different areas to see if the impressions I had formed during observations and informal interviews during the research project were prevalent throughout the community. This section discusses the effects of the forced removals and describes the community during the pilot integration project. I also collected data on health and the health centre which will be presented in the main analysis (Chapter 6). Also, I asked residents for suggestions of how they would solve some of the local problems. I felt this was important because community participation (as defined for PHC) requires such investigation. This section, including the discussion of Paradise Park in the media, shows my background most clearly (see section 3.6 on the facilitator). I acknowledge that idealism exists in using my data to look at problem-solving. Also, my irritation at stereotyping is palpable when I discuss the media. I have not tried to make this showing of my irritation more objective for two reasons. First, these are real issues that should be unpacked for successful implementation of integration that includes community participation. Second, the sections show very clearly with which attitude I, as an active participant, held in the process.

The quote at the start of this section is one of many that show how the removals changed families. Before the removals, the quoted family were farm workers with plenty of space to live and for children to play. The family seems to have had sufficient money to sustain them and knew of ways to use the surrounding flora for health care. After the removals the father had to change work from farming to two new professions. This suggests the family were struggling to make ends meet. As described in section 3.5 on landscape and meaning, the sea is dangerous and cold on the Paradise Park side of the mountain. Fishing would have been a difficult profession to follow. The father's drinking and lack of interest in herbs suggests resulting depression. The surrounding area in Paradise Park has similar flora to the pre-removal areas. As Chapter 6 will show,

many men continued using herbs for health and healing. His daughter (in her thirties, married, with children) seems to have settled well in Paradise Park. However, those of her father's generation are still alive and keep the memories of that the time of forced removals alive.

It was my impression that isolation had given Paradise Park an overall small village attitude. When people are home their back-doors are kept open. This was unusual when compared with most (if not all other) areas in Cape Town where back-doors, front-doors and windows are all barred. Paradise Park can be divided into several smaller areas. Each area is distinct as they were built at different times and for different purposes (flats for single mothers, the navy houses, etc.). In any given area or even in one street, my impression was people all know each other, and looked out for one another. However, the perception of a small village is relative and feelings about Paradise Park among residents were varied:

Wouldn't swap it for the world. (K11)

Paradise Park is a clean place ... Nice place to live. Safer than up the line. Whatever happens people know about it. (I77)

Jij is nie meer veilig ni.e. vooral in die avond als jij gaan stap bij die flats. (translated as: you are not safe anymore, especially when you go walk near the flats) (I81)

Here in Paradise Park there is nothing - not like up the line. (I89).

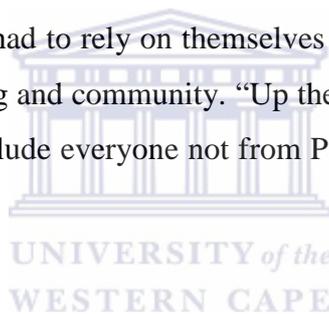
The interviews portray a unique picture of a distinctive community. Religious attitudes are an example of this distinctiveness. Religion is a prominent aspect in life: everyone belongs to a denomination. A person's faith, however, is not a source of strife. In the old age home, Catholics live with Protestants and Muslims. I met several families that included one Muslim and one Christian parent. Perhaps the feeling of "us" is so great that all other differences are settled.

Unemployment and poverty are seen as the two major problems in Paradise Park, and associated with causing alcoholism, drug abuse, domestic violence and crime. 20% percent of respondents suggested reducing poverty by building more shops. As well as providing employment, the community would gain access to cheaper, and a wider variety of, goods. Another suggestion (from 35% of the respondents) was to better use the skills available in Paradise Park. As well as providing better opportunities for people of Paradise Park, this suggestion is related to feelings of community belonging:

Why do they not give the job to people of Paradise Park? Why do they have people from up the line? (I32)

There is a lot of nursing staff in Paradise Park. They have a better understanding of their own people. They will understand people. (I36)

People of Paradise Park have had to rely on themselves and their use of language helps create the feelings of belonging and community. “Up the line” refers to all areas outside Paradise Park. “Outsiders” include everyone not from Paradise Park, regardless of their race.



The many social problems in Paradise Park cannot be ignored. Problems stemming from criminal intent or addiction threatened the sense of safety in the community. These quotes from the interviews reveal perceptions of high levels of crime and social problems such as murder, rape (including as gang revenge for something a family member has done), breaking and entering, alcoholism and drug abuse:

She was so small; only nine. They dragged her from the front gate and raped her up at the greenbelt near the high school. That really messed her up. She is seventeen now. She lives somewhere in town. I don't know where (My field notes, March, 2002).

Ons hoor ook ma net van die moord (translated as: We only just heard about a murder). (I40)

There was a stab on Friday night. (I78)

I got my pension for the first time. I went shopping like crazy. I went out; they broke down the back door and stole all the meat from the fridge. (I72)

There are 24-hour shebeens⁶. (I37)

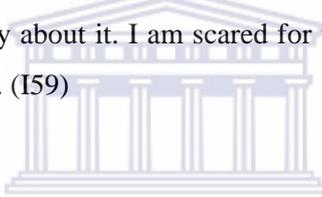
People drink too much. (K8)

They are local [drug] sellers. Kids don't pay them what they owe and they hit them. "Your own mother don't know". (I48)

Gangs are part of the Paradise Park community, but they are seen more as a potential threat for the children (as future gang members):

The gangsters know us. They leave us in peace. It is our children I worry about. (I47)

Gangsters fight amongst themselves (drug-related). Personally staying here they do not interfere. I do not worry about it. I am scared for the children, for them to get involved. We live around it. (I59)



In the interviews, one area is associated particularly with criminal activity. The local flats are blocks of two to three levels from which, bad things emanate or happen. This area is seen to be inhabited by a different, lower, social class of people who have little education, are unemployed and are involved in criminal activity:

The wrong kind of people stay there. (I76)

Jij is nie meer veilig n.e. vooral in die avond als jij gaan stap bij die flats. (translated as: you are not safe anymore, especially when you go walk near the flats). (I81)

However this generalisation was not held by everyone:

⁶ A *shebeen* is an illegal café, often situated in someone's garage, selling illegal alcoholic drinks.

Oh well, you hear about something happening at night, and you hear there has been a murder but it is not always there [pointing towards the flats]. (Uncle Thomas, 5th August, 2002, key interview)

Such problems were seen to influence children adversely. Interviewees suggested children should be occupied in a constructive manner to avoid problems now and when they become adults:

Kids don't go to school and are smoking dagga and that. (I78)

Children that smoke glue. (I89)

A girl came out pregnant – a child with a child. She can't go anywhere – someone has to work. The father doesn't want to. (K10)

The main problems identified affecting children were dropping out of school, drug abuse and teenage pregnancy. One schoolteacher suggested that some girls prostitute themselves to earn money⁷. The suggestions from residents focused on occupying children after school, at the weekend and during the holidays⁸. Many of these suggestions are cheap and feasible. Skills from adult residents could be used to occupy the children. The materials needed are either cheap or people have them at home. Additional funding could be found for additional material and perhaps snacks for the children. The suggestions included the following:

- Using the multipurpose centre and the sports field for sporting and play activities.
- Teaching children usable skills such as sewing, dressmaking, pottery, painting, and building.

⁷ This teacher followed some of his pupils and found they were picked up by a man in a car. He took them to Kommetjie. The teacher found the girls were left behind in a container fully decorated with bed, sofa etc. He added he understood why this happened. The promise of money and a better life is enough to lure these girls into such relationships.

⁸ 30% mentioned the need to keep the children occupied. Suggestions included a disco, cinema (3%) and swimming pool (4%).

- Vegetable gardens could be planted on the school grounds and other open areas.⁹

As well as occupying children, adults would be involved actively, creating new social bonds and networks. Products and produce could either be sold or used to supplement (in the case of produce) meagre diets.

In addition to criminality and addiction, police were viewed as inadequate or even corrupt:

They are not helpful. You go to them with cases. They don't come out. (I52)

The police are corrupt. I know of stories. A mandrax¹⁰ drugs dealer was caught, paid the officer and he was gone. You have one policeman covering for another. (I63)

This boetie boetie¹¹ business, drinking with the chaps – that is what I saw. Very chummy. If you work for the law you are not a friend. (I75)

As before, we find Paradise Park residents making the distinction between outsiders and insiders; in this case, the police force:

Some are from Paradise Park, some are not. The ones who are not from Paradise Park do not care. The ones from Paradise Park are familiar to the ones – some know the location of the mandrax seller. (I63)

⁹ A successful garden requires a plot around the size of a door to feed a family.

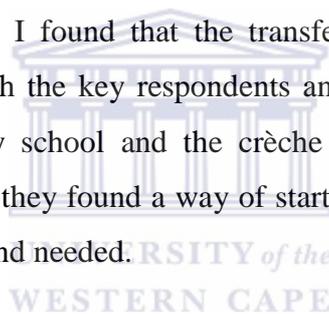
¹⁰ Mandrax is a synthetic drug in tablet form consisting of a mixture of methaqualone and diphenhydramine, an antihistamine. The ingredient, methaqualone, is a synthetic sedative-hypnotic which acts as a central nervous system depressant. Mandrax is smoked usually with a mixture of cannabis and tobacco. This is called a 'White pipe' (In Paradise Park it is always referred to as 'smoking mandrax'). The SA health website (www.sahealthinfo.org) links drug use (cannabis and mandrax) with violence, property crimes, organised crime and gang-related activities.

¹¹ *Boetie* is the Afrikaans word for 'brother'.

This insider/outsider attitude, originating in the community being left to their own devices, is characterised by them wanting to do everything themselves and disliking being taken over by outsiders. Not only are outsiders employed to do jobs residents are trained to do, but insult is added to injury by the outsiders arriving and setting out to fix all problems through their projects and research. As one of my fellow researchers in Paradise Park pointed out: “Upliftment programmes means admitting that something is wrong in the community”¹². One of the residents said this:

It’s a funny thing in Paradise Park. When you do that [participate], people think you want to stand out, look educated. No one will come. (K10)

Moreover, although many social and welfare organisations address the problems in Paradise Park residents felt that existing skills should be used, especially to help the children. During my research I found that the transfer of existing skills is seen as feasible. I shared my data with the key respondents and the sharing of existing skills was taken on by the primary school and the crèche owner as a project. With the information from my research they found a way of starting a project based on what the community said they wanted and needed.



Social services

Several organisations in Paradise Park address social issues such as disability, old age, housing and poverty.

The Centre for Disabled People plays a major role in the lives of disabled people and their families. The centre started as an activity group in 1972, expanding to a workshop in 1979. Each weekday, disabled people from Paradise Park can work at the centre for a

¹²Kashifa Occupational Therapy, University of Cape Town interview 31 May, 2001.

small salary to supplement their disability grant¹³. The centre does shoe repairs, recycling, sub-contracts from factories, crafts and sells cleaning materials. A community worker and a social worker are tasked to help solve the problems of disabled people coming to the centre¹⁴. The community worker stressed that common problems include financial and emotional abuse in which the family take the grant money, or tell the disabled family member that he or she is *mal* (crazy), or doesn't know what he or she is talking about.

Many elderly people in Paradise Park remain with their family or have a married child and their family living in with them in their own home. However, other elderly people are more vulnerable and lack housing. In one of the central streets in Paradise Park a house was transformed into an Abbyfield Society of South Africa home for elderly individuals. The society originated in England and its goal is to house elderly people in their own community so they can keep in touch with their families. The home in Paradise Park, called *Ons Huisie*¹⁵, houses five women who have their own room while sharing a kitchen and living room (Fieldwork, April, 2002).



Another major welfare organisation is the Valley Development Project, which focuses mainly on welfare and also has training and intervention projects¹⁶. The Project, which has been functioning independently since 1994, helps with grants and runs a pre-school. Poverty and unemployment are addressed through the bakery and gardening projects. People are trained in these new skills and can take home food they make or grow. Their most prestigious project focuses on training and life skills of youth at the high school.

¹³ 57 people work in the workshop. 14 profoundly disabled people are in the special care unit. The monthly salary of only R60 ensures the workers do not lose their disability grant. For comparison at the time \$1 was R10. So R60 would be around \$6. Considering this in terms of the international poverty line of \$1 per day, \$6 per month is far below this. Interview with Dawn April 2002.

¹⁴ Interview with community worker, April, 2002.

¹⁵ Translates as Our House.

¹⁶ Interview, April, 2002. 80% of the Project's effort is on welfare, with the remaining on training and intervention. Their 30 staff members include teachers, project managers and social workers. One of the three social workers works in Masiphumelele.

The Peninsula Feeding Scheme supplements the diet of more than a quarter of primary-school children¹⁷. Children receive bread, peanut butter and jam once a day. Other organisations include Open Door¹⁸ dealing with abuse and neglect, Development Trust¹⁹ which focuses on housing development, the Rotary Club and Living Hope.

The media: the reproduction of an image

Earlier in this chapter (see section 3.3) the reproduction of stereotypes and attitudes towards Coloured people was discussed. It has to be noted here that reproduction in the media is a specific kind of reproduction different from the other manners in which stereotypes are reproduced as mentioned under section 3.3, such as education or informal discourse. First, at the time the media such as newspapers and television was very much the domain of the White minority. Media stories were mainly made and consumed by White people, including me. Newspapers are expensive and some are only distributed in certain areas while televisions and reception was more common in the White areas. Second, media is produced for the purpose of profit and thus will produce what sells. This discussion about the media has been placed here to help the reader visualise the production of stereotypes and attitudes, and place some of the discussion about interventions in context. As Soudien (2001) points out in a discussion of District Six and the production of identities, it is important to remember that the relationship between what is formulated by a dominant group is not the same as the lived experience of subordinate groups. Nothing has been written about how Paradise Park responds or feels about the stereotyping in the media, although the discussion on outsiders might be a hint to this (see section 6.5). The rhetoric in the media concerning Paradise Park at the time of research can still provide a good example of prevailing ideas and feelings

¹⁷ Marine Primary School has 1,100 pupils of which 292 (27%) are fed by the scheme.

¹⁸ I made several appointments to meet the social workers; however, they had always just left when I arrived. Although unfortunate, I appreciated they had busy workloads.

¹⁹ The Trust was situated in a house surrounded by a high fence and a (always closed) gate. Perhaps they opened when I was not there. One key respondent, who used to be on the Trust's board, said: "They are intoxicated with money. I was on the board and they have no feeling for the people" (K8).

towards Coloured people. The average Paradise Park resident, according to the media at the time, is a fisherman, drinks and abuses his wife and children and lives in a dirty flat in the middle of a barren dessert. As the following cases show, this image is reproduced over and over in the smallest detail in the media.

Television: *Strong Enough* ETV documentary, 2001

This truly wonderful documentary on fisherwomen in Paradise Park fell, most likely unwittingly, into the stereotype trap. The goal of the documentary was probably to portray a picture of strength and survival, but it ended up reinforcing the existing stereotypes present in South Africa. These stereotypes are held and reproduced by White people and internalised and subsequently also reproduced by Coloured people.

The documentary makers have made some very deliberate decisions about what to show of Paradise Park and how to portray daily life. These decisions resulted in Paradise Park being presented as a predominantly fishing community. The documentary shows the flats areas only. In their quest to show a community suffering relentless poverty and unemployment, Paradise Park was portrayed as dry and devoid of any greenery. Apartment buildings with three-storey flats had graffiti on the walls and washing suspended between buildings. The documentary footage shows men playing dice all day, dirty children and dogs playing. People live with alcoholism and domestic violence.

A visit to Paradise Park and analysis of my data above shows an entirely different picture. The two main problems in Paradise Park are indeed poverty and unemployment, and women show enormous resilience in taking up fishing. Alcoholism and domestic violence are part of the daily reality. However, Paradise Park is as far from being a fishing community (a misrepresentation) as any suburb formed by people from different areas and different occupations. As the research in the community conducted by me pointed out, only 6% of men and 1% of women are involved in the

fishing industry. Fishing is the joint fourth most common profession for men. Maralack and Kriel (1984, p.21) support this conclusion:

Fishing is generally regarded as being the traditional form of employment. However, when these fisher folk were moved to Paradise Park, away from their source of employment, the fishing community tradition ebbed.

Their report agrees that fishing was the traditional occupation for many, but declined after the forced removal with the need to earn a regular and stable income for rent, increased transport costs, etc. Men chose building and the dockyard trades whereas women mainly worked in the commercial and service sectors. The report based on research conducted 15 years after the removal already states that “the fishing industry is now, 15 years after the first removals, a minor source of employment; fishing in Paradise Park is a dying tradition” (Maralack and Kriel, 1984 p.21). The decline of fishing as a traditional occupation would have continued after this research and more than 30 years later it is, as my community research suggests, basically gone.

The flats area shown in the documentary is a very small part of Paradise Park and is identified by people from Paradise Park as an area of high crime and violence. Paradise Park is made up by several different areas, many with bungalows, plots of land (some with gardens), playgrounds, sport fields etc. Some areas are beautiful, others less so.

A closer look at the documentary reveals the reproduction of old stereotypes and a failure to show strength and survival. A wonderful documentary with women speaking for themselves is ruined by the portrayal of their community in which the exception of women fighting for themselves proves the rule against apparent Coloured impotence. Instead of an exception, the fisherwomen are portrayed as another example of creative survival of women and men under negative circumstances. The stereotypes of laziness, drunkenness, gambling, crime and violence reproduce the existing views of Coloured people. Moreover, the images of dirt and barren surroundings emphasise the existing image. The documentary portrays only a small portion of Paradise Park, its real relationships and circumstances.

The documentary reproduces the stereotypes described by Western (1996, p.15), stemming from Jan van Riebeeck's ideas of the Khoikoi as "savages" and "lazy stinking people" and the British paternal tone towards Coloured people. The stereotypes presented in this documentary are drunkenness and involvement in crime and violence (Western, 1996). It presents an overall image of the "child-like qualities of Coloureds", assuming Coloured people are ignorant, fecklessly irresponsible, and vulnerable (Western, 1996). Overall, an image of hopelessness and powerlessness is presented (Western, 1996). The documentary even ends with images of the Coloured people as musical stereotype (Western, 1996). The truth is that although a lot of alcoholism and violence occurs, this represents only a small percentage of the whole Coloured community or the Paradise Park community. The White stereotype has been internalised by many Coloureds (Western, 1996). This negative image is held by White people and Coloured people from other areas, middle class or not.

Television: *Waiting to go Home* ETV documentary, 2001

Waiting to go Home is a documentary on the forced removals in the Cape Peninsula and the progress of land restitution seven years after the first free elections of 1994 and the institution of democracy. Paradise Park is one of the communities discussed. As Western (1996) notes, the documentary implies that only people from Simon's Town were moved to Paradise Park. Similar to many of the newspaper articles of the time of the removal (see section 3.3), the documentary emphasises how Simon's Town became a ghost town and businesses suffered from the removals.

Paradise Park is introduced as follows by the narrator and producer Melanie Rice, while showing the same image as the *Strong Enough* documentary (the area of flats with its graffiti, dogs, dirt and washing suspended):

raise their families in a wasteland called Slangkop. Today it is called Paradise Park. There is still no paradise and no park. The community that lived of the sea was dumped in a barren desert. Families and neighbourhoods were destroyed, poverty became entrenched. The community was ripped apart, livelihoods were destroyed

and people were thrown into suburbs of strangers. It became a breeding ground for gangsterism.

The reference to strangers implies that other people were living in the area, but their origin is not explained. This reference leaves intact the misrepresentations of Simon's Town's origin and that only the Coloured population of Simon's Town suffered. Note also the reference to fishing in "lived of the sea", whereas in reality many worked for the dockyard or municipality.

Of all the things one could emphasise in such a documentary they chose to reinforce the stereotypes through image and choice of narrative.

Newspapers: *Falsebay Echo* free community newspaper, 2001

The *Falsebay Echo* was chosen as it is distributed for free and read by people in Paradise Park. It presents the image of Coloured People and reproduced through its readership in all areas of Falsebay. Categorising newspaper articles concerning Paradise Park is revealing:

- Fourteen references to fundraising, development or charity. The articles range from reports of development programmes (such as teaching children how to react in an abusive situation²⁰), to pleas for funding operations for children²¹.
- Nine references to fishing. The articles deal with men dying while at sea²² and complaints from a nearby community about subsistence fishing²³.
- Four references to crime. The articles mainly deal with vandalism and breaking and entering of several crèches in Paradise Park²⁴.
- Four references to sport.

²⁰ *False Bay Echo*, 28/06/2001: Kids taught how to react to abusive situation"

²¹ *False Bay Echo*, 12/04/2001: "Give little Pedro the gift of sight".

²² *False Bay Echo*, 9/08/2001: "Paradise Park family mourns their fisher sons".

²³ *False Bay Echo*, 22/02/ 2001: "Foul fishermen anger residents".

²⁴ *False Bay Echo*, 7/06/2001: "Crèche cleaned out by thieves" and *False Bay Echo*, 19/07/2001: "Vandals target Paradise Park crèche".

- Five references to other news such as taxis and deaths.

Unfortunately the stereotype of the fishing people relocated from Simon's Town is continued through these documentaries and newspaper articles. The media create the image of the Paradise Park fishing community in need of aid and riddled with crime but thankfully they are very good at sports. The first part of this chapter has painted an entirely different reality of Paradise Park residents in different professions originating from different areas of the Cape Peninsula. Crime and unemployment are as much a reality as white picket fences.

3.6 Facilitators

As I will show in Chapter 4 of the thesis, the facilitators played a central role in the integration project. I will discuss Yvette in Chapter 4 on Planning. Here, I want to reflect on my own background and to consider whether it could influence my interpretation of the data. This is of particular importance due to my active role in the project. The start of the new pilot at Paradise Park coincided with the beginning of the Administration of South Africa project. I was chosen to do the fieldwork in the CHC, observing the change in a facilitated integration pilot project from the grassroots level. One requirement for my involvement from both SAHA (Initiative for Sub-District Support) and the DoH was that I should play an active role in the pilot integration project, which I did. This is why I chose to present my data fairly strongly from my point of view. I feel this approach is justified as I was as insider to this process.

My gaze

I grew up in the Netherlands. My parents and their friends were strongly politically left-wing. Consequently, we took part in many of the large demonstrations in the 1980s against nuclear armament and Apartheid in South Africa. I remember once picketing the offices of the Shell corporation in The Hague at the age of 10 or 11, with the aim of forcing Shell to move their business out of South Africa. Reflecting their political

beliefs, my parents encouraged my interaction and acceptance of all people, no matter their background, religion, creed or life choices. My choice to study anthropology emerged also from my upbringing. I felt a need to help vulnerable persons; for example, I worked with Moroccan women who had arrived in Holland as part of an arranged marriage and who could not speak Dutch. I wanted to find a way to help them.

During my studies in anthropology, I took a different direction and in 1997 I moved to South Africa, only a few years after the first democratic elections. I suppose I should have expected that the issue of race was everywhere: in newspapers, on the television, in conversations, and in academia. I was most surprised, when I told people a story about someone, they would always ask me the colour of the person. For instance, I once told a middle-class White English expat in his late thirties about a student who asked me for an extension for her assignment. He then asked me what colour she was. I did not see how that was relevant to my conversation with the student, but for him that was essential. Of course, colour was present in the context of my conversation with the student. The student was Black and because of Apartheid, was living in one of the Black townships. As discussed in sections 3.3 and 3.5, Black townships are not in the best locations which mean, for instance, excessive flooding is likely when it rains and the temporary housing might collapse. This student's work had been ruined during one of these floods. My conversation with the student had a background based in race, in this sense. However, I confirmed that the White expat was asking whether this student, depending on her colour, might have been lying to me. The question about the skin colour of this student did not relate to my actual conversation with the student. It is the man I was talking to who forced a race lens over the conversation. He had arrived in South Africa 15 years earlier and therefore had been exposed to Apartheid-controlled media. Even when I arrived in South Africa the media reported mostly on national news. Access to international news was limited, especially as the internet was not widespread. His lens was one that had been built up over 15 years through reproduction of the race image through the media, the isolation from other groups (e.g. from Coloured and Black through the Group Areas Act), and his lack of knowledge of other languages. This is a similar view on colour as the one held on Paradise Park and by the media in section 3.5. Another part of his race lens might have been his class. Being

middle class, as I noticed with all his friends, meant that he did not have funds or property overseas and, although living comfortably, paying for the children's university fees and a local pension was often difficult. These were often topics of conversation during *braais*²⁵ I attended. After the democratic elections there must have been a fear of jobs being taken by Coloured and Black people and possible landgrabs such as in Zimbabwe. As the middle class, such as this man, had nothing to fall back on, it must have been frightening and made the Apartheid-constructed colour categories stand out even more vividly.

I want to discuss my background for two reasons. First, the perception of the South African race lens does not come naturally to me. For instance, I would not have wondered immediately if a speaker's race affects how they perceive the world. This became most obvious to me during analysis for the thesis. I started to realise how vital it was, for example, that a doctor was White, or that being Afrikaans or English is an important difference. However, I never asked. As another example, during the writing I suddenly remember that a certain nurse lived in the Lavender Hill township. However, I did not ask her about this directly during the research. Travel is easier from Lavender Hill as it is situated on the main road and train line. These good transport links could have facilitated her education²⁶. On reflection, I realise it would have been very useful to know all the nurses' home locations.

Second, I am much more aware of the clear mention of race differences due to my upbringing. As in the example above, I have learnt to apply the race lens to my data, even if race is not obviously referred to in a conversation. I have not always managed this successfully. I remember one conference presentation in which I talked about the insanity (I believe I used that word) of using words such as White, Coloured and Black. I was not able to distance myself and understand that a race lens has meaning, is

²⁵ Used for barbeque in South Africa.

²⁶ For comparison, the nursing auxiliary in the research was probably the same age as this nurse. However, the nursing auxiliary from Paradise Park (with its poor transport links) did not attend school but learnt nursing in Paradise Park.

contextual and adds value to insights on any topic or interaction based in a history such as that of South Africa. My feelings about race stopped me from seeing how critical a race lens is for South Africans. At times, their reactions just infuriated me and prevented me from asking questions to increase my understanding. Someone called me liberated recently, but I think I am the very opposite. I am, just like everyone else, enslaved by my perspective of the world.

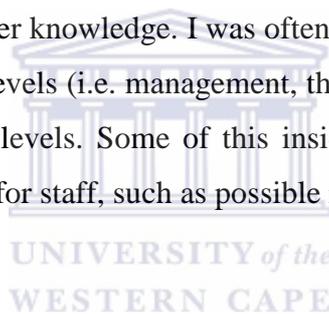
Also, I realise now that my background and idealistic choice of anthropology made me more sympathetic towards the clinic nurses who know the community. These personal characteristics might have blinded me partly to how nurses of both the day hospital and clinic view their own practice. I found the racist remarks that were made occasionally by (particularly White) day-hospital staff very difficult and did not ask enough about this. For the thesis, I have had to learn to analyse race and consider my own limitations in understanding its importance.

My interest in race inequalities in this thesis is thus not surprising. I need to acknowledge here that I have paid less attention to other dimensions such as gender, regional, religious, cultural and class identities. Although the race categories constructed under Apartheid still have an influence today, other dimensions have always played a role. As Erasmus (2001 p.6) points out “cultural, class and regional differences in coloured identify formations are not simply white-imposed”. Ignoring other dimensions is to deny agency in which identities are created and continually change over time. They are influenced by, among others, national and local factors and interaction with others. Due to my background, I, to some extent, fall into the trap that Zegeye (2003) warned about, that is “the fiction that all black people are the same”. Although I have a particular interest in race inequalities, I have attempted to include other dimensions in this thesis.

My role as a researcher

The ethics of anthropology is bound up with ethnography as a discourse of responsibility, in the sense of a discourse of reflexive awareness achieved across difference. (Battaglia, 1999 p.75)

As stated earlier in this section, I played an active role in the pilot integration project. What roles did I take? Besides the expected tasks of researcher to interview and observe, I was a co-facilitator in staff workshops and joint planning meetings. Also, I was an observer in staff meetings and a participant observer at the CHC. This myriad of roles offered an extensive and unique view of the CHC and its community. However, this advantage of multi-levelled access through active participation was marred slightly by my gaining privileged insider knowledge. I was often aware of thoughts, policies and actions from one of the three levels (i.e. management, the NGO and the CHC) that were unknown to any of the other levels. Some of this insider knowledge could have had potentially negative outcomes for staff, such as possible retrenchments.



By being a co-facilitator in staff workshops and joint planning meetings, I could observe the thought processes behind the workshops and meetings. As well as observing the planning by facilitators and management, I observed its impact on the receivers. This part of the research actually offered a more extensive view of the process of change but also posed some dilemmas for my personal and professional values. This is why I feel it is important to employ Battaglia's (1999) reflexivity, not to mitigate and minimise but to engage and take responsibility with this active role. For this reason I have included my own perspective strongly in the analysis.

The extent of the role of co-facilitator and the relationship with the facilitator was limited to the process of integration. Workshops were planned by the facilitator and then discussed with me. We would discuss the goal of a workshop compared to the current situation at the CHC. I would brief her on the situation at the health services,

pointing out the problem areas. The facilitator used this information to focus and workshop through the real concerns of staff. Obviously this was a very sensitive issue and a precarious position to be in as a researcher. This type of interaction brings up issues of confidentiality and the betrayal of trust towards the staff.

It is difficult to realise fully beforehand the consequences of an active role. Moreover, no-one could predict at the start of the pilot integration project what the active role will entail, and you are swept along by events along with health services staff. However, this does not exempt me as researcher from responsibility of any part I played in the process. As for not being able to blend in the background we are not able to be objective and can only claim awareness as a reflexive exercise as Barnard and Spencer (1996) note:

An anthropology of modernity would employ ethnographic holism to dissolve the illusions that convince us that we are modern, unprecedented but objective observers of other people's cultural worlds. As yet such an anthropology hardly exists ... it would be far more empirically challenging.

As I have already suggested, and will endeavour to reiterate during the analysis, I was not an objective observer in any shape or form. My background alone causes me to have a subjective view of the pilot integration project and everyone involved.

3.7 Conclusion

In this chapter I have presented the framework in which the data collected during my fieldwork needs to be understood. The historical context, the international arena, the present context, and the facilitator are all facets which are important in understanding the dynamics of the pilot integration project in which dominance and resistance played themselves out among the different actors. I have chosen to go to this depth of background to allow the reader to fully understand the context in which the pilot project took place. In the next chapter, the planning of the project by Yvette (the facilitator from SAHA) will be analysed and discussed.

Chapter 4 - Planning for integration

The aim of the Paradise Park Project is the integration of the existing clinic and day hospital into a single Primary Health Care facility offering quality health care to the Paradise Park community. (Owens, 1999b)

The Paradise Park Project, as it is called in the aim, officially started on the 7th October 1999. Before this date the appointed facilitator spent several months preparing carefully for the project. This chapter will focus particularly on her choices, her thoughts and plans during this period. As will be shown, she was pivotal to the choice of the site for this integration project. As shown in Chapter 3, the manipulation of Space was a key feature of the Apartheid era. Thus I have found the concept of Space particularly useful in analysing this part of the planning process. The facilitator wrote all the guidance documents to prepare for this project, including an analysis of former projects and a development plan. Also, I will analyse her views of the main actors in this project including the managers, the staff, the community and myself as her co-facilitator. As some of the data analysed in this chapter are from documents, I have found narrative analysis very useful in providing insights on what was written in the documents and more importantly, what was omitted. I will show that the facilitator played a role closely linked to that of a magician, guiding and structuring the change process for the Paradise Park Project.

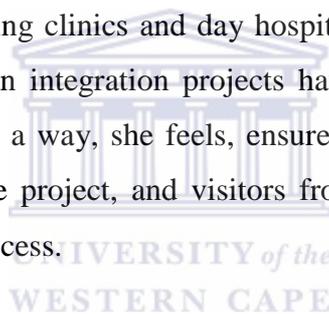
This chapter will cover the planning process and the launch of the project with the initial responses from staff. The next two chapters will then analyse in depth the actual responses to the process as the project followed the development plan.

4.1 Choosing Paradise Park as the pilot site

The choice of Paradise Park is important. The site is unique with two services in one building. (Yvette, September, 1999)

The quote above is from my first meeting with Yvette when we discussed the launch of the Paradise Park pilot integration project. She said she pushed for this site as the next project site since it is quite unique in the Cape Peninsula and perhaps in the country. She tells me there are two reasons why she chose this site:

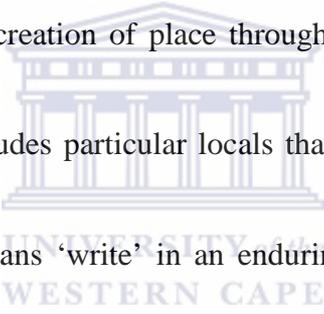
- a) The above quote highlights the first reason, in that Paradise Park is one of few sites that houses two services (the municipal clinic and the provincial day hospital) in one building. She felt this should make the facilitated process much easier as the staff meet each other during the working day as they move through the building and in the communal tea and lunch room.
- b) The second reason focuses on the geographical isolation of Paradise Park, described in Chapter 3. This isolation means that interference from staff members in neighbouring clinics and day hospitals will be limited. This is one reason why other urban integration projects have failed, according to Yvette. The isolation would in a way, she feels, ensure that only the staff of Paradise Park is involved in the project, and visitors from other facilities cannot offer their opinion on the process.



Her two reasons for the choice of the site, particularly its isolation, need to be seen in the historical context. Chapter 3 expands on both the origins and the present context of Paradise Park. Here I will just summarise a few details for clarity. Paradise Park is a township created under forced removal during Apartheid. During Apartheid, Paradise Park was planned on the side of the mountain where it is windy, the lands are arid and the Atlantic Ocean is very cold due to the Benguela current. The more lush and gentle side of mountain where the Indian Ocean is fairly gentle and warm were kept for the White citizens. Paradise Park is in an area that is isolated from amenities and public transport is sparse. It is not a place that is either easy or attractive to visit (see both historical context and present context for discussions around the creation of segregated space in Chapter 3 - Dominance and resistance). The forced removals are an example of the deliberate and legislated act of the manipulation of the landscape by those with power. As Kuper (2003) points out it is one the most blatant and deliberate examples of

Contested Space. For South Africa, I have defined this as follows in Chapter 3: the use of the landscape to control residence, economic opportunities, social spaces, access to amenities and mobility by a powerful minority with the majority control of resources during the Apartheid era (see the historical context for discussions around control of resources in Chapter 3). Paradise Park is a product of Contested Space and it has left the area in geographical and economic isolation.

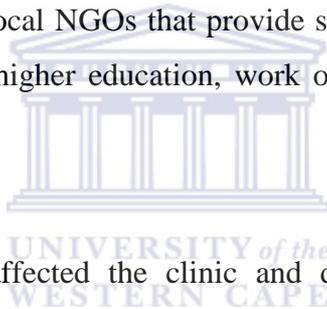
As the introduction stated, Space was found to be very useful in the analysis for this chapter, and it will feature as a main theme. The meaning of space and place was explored in section 3.5 on Present context. Here, I will explore the concept of space further from an academic perspective. Low and Lawrence-Zúñiga (2003) divide Space into six thematic categories:

- 
- a) Embodied space: “the creation of place through spatial orientation, movement and language”.
 - b) Gendered spaces: “includes particular locals that cultures invest with gendered meaning”.
 - c) Inscribed spaces: “humans ‘write’ in an enduring way their presence on their surroundings”.
 - d) Contested spaces: “geographical locations where conflicts ... engage actors whose social positions are defined by differential control of resources and access to power”.
 - e) Transnational spaces: “global, transnational and translocal spatial transformation produced by the economy of late capitalism, focusing on people on the move”.
 - f) Spatial tactics: “the use of space as a strategy and/or technique of power and social control”.

Kokot (2006) suggests that anthropology does not have a fully-formulated theory of culture and space. Nevertheless, Low and Lawrence-Zúñiga’s book is probably the most comprehensive exploration of Space and Place. Kokot engages with the main critique of culture not being bound by Place or Space, particularly in a world where globalisation influences boundaries. I believe this is taking the concept of Space too far as I agree

with Low and Lawrence-Zúñiga (2003) that “all behaviour is located in and constructed of space”. Globalisation and changing boundaries are part of this the definition of Space and feature as Part 5 (Transnational Spaces) of their book. Particularly in a context like South Africa where Space and Place were constructed as much as skin colour (see section 3.5), space can provide additional insight into the behaviour of various actors.

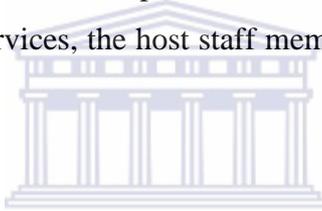
Sections 3.3 and 3.5 showed how the forced removals to Paradise Park caused increased poverty, particularly through isolation as residents were less able to travel to reach education, services and job opportunities. However, Paradise Park was not left completely without amenities. Water and sanitation were present, as were a primary and secondary school, police station, clinic and day hospital run by various ministries. Small shops, churches, some private doctors and NGOs have established themselves overtime. Chapter 3 also described the local NGOs that provide social, welfare and development services. However, access to higher education, work opportunities and tertiary health services is still difficult.



This geographical isolation affected the clinic and day hospital staff. During my fieldwork period, staff members rarely left the building on their lunch breaks and spontaneous visits from colleagues never occurred. Those staff members from outside Paradise Park (which includes all staff except the general workers) used to arrive each day in their cars and did not tend to leave until the evening. The beach, supermarkets or restaurants which might be destinations for lunch times are all at least 15 - 30 minutes' drive away, as were other clinics and day hospitals. Comparing Paradise Park to a clinic/day hospital such as Diep River, as Yvette did in our first meeting, it became clear quickly how different Paradise Park was as a location.

Yvette told me that Diep River health services had gone through some change processes, although not integration. The Diep River health services are situated in the middle of the southern suburbs of Cape Town. Access to these services is easy as they are situated on a main road between Cape Town and Simon's Town, serviced by public transport including a train, minibus taxis and buses. Both the main road and the M3

highway, running from Cape Town city centre to Fish Hoek, make access easy by car. The primary hospitals can also be found along this route from Somerset Hospital near the Waterfront in Cape Town city centre, and Groote Schuur Hospital in Observatory, to False Bay Hospital in Fish Hoek. Clinics and day hospitals in the Southern suburbs are dotted around this same main road, as are the main administrative centres for both the municipal and provincial health services. This spatial pattern meant that medical staff were moving up and down this main road being deployed for cover, visiting colleagues, or for administrative or training purposes. Quick trips could even be made over lunch times for staff members to meet up. Comparing this to Paradise Park, the Diep River health services can be more easily visited than Paradise Park for which a special journey has to be made across a mountain pass. Yvette explained that in previous changes initiated in health services such as Diep River, staff members from other services tended to drop in to give their opinions on the process. As the visiting staff members make comparisons with their own services, the host staff members can become more resistant to a change process.



The other reason for the choice of this site, more directly alluded to in the quote from Yvette above, was that two services exist in one building. The health services in Diep River illustrate the advantage of this arrangement. In Diep River, the clinic and day hospital are on one site but in separate buildings. A staff member would have had to cross the court yard to reach the other service. Staff members did not meet each other as they went about their daily practice. Yvette told me that when changes were introduced, staff members just stayed in their buildings and ignored the other service. Resistance to change was easy as meeting the other staff members required the extra effort of crossing the court yard. It occurs to me that in Diep River, staff members were not observing the daily practice of the other service occurring in another building. Staff members might not have been aware of what the other service does.

With the two services sharing one building in Paradise Park, however, staff members will have met routinely throughout the day and share a tea and lunch room. The staff were aware of the patients of the other service, referral could be done personally and

daily practice could be observed readily. A facilitator could more easily observe staff as both services were operating in one space. The one building, alongside the geographical isolation, created an opportunity for more control. I would like to call this Controlled Space. This is a new concept within Space and I see it as a particular spatial attribute being turned into an opportunity for control. In combination with geographical isolation, it means that the facilitator always knew where staff members were going to be at any time of the working day. Controlled Space does feel like it is closely related to Spatial Tactics. This concept represents the use of space as a strategy or technique to exert power and control (Low, 2003). Although presented as neutral, the space hides the real power play and control beneath the surface. As Low (2003) points out, Spatial Tactics often are embedded in architecture and spatial arrangements of a place. Spatial Tactics is different from Controlled Space in that Spatial Tactics is more based in the manner in which architectural design is used. Modern examples are gated communities. The most used example is from Foucault's (1975) work. He saw a particularly close relationship between social control and architecture in his exploration of the Panopticon: an architectural design in which a central observation point is used to observe and control people such as in prisons and hospitals. South Africa's forced removals are bigger than Spatial Tactics in that they included the whole landscape and they had a deliberate influence on many socio-economic factors. The choice of a building with two services is smaller than Spatial Tactics. Also, it is not a creation of a building to exert power: it is merely an opportunistic choice which might allow greater control.

The greatest critique of using Controlled Space as an opportunity for control is that it seems to ignore the possibility of resisting the play of power. Although Controlled Space allows the process to be more easily controlled, through the geographical isolation and staff not being able to ignore each other, these are flawed arguments. In terms of geographical isolation, all nursing staff, some of the administrative staff and the doctor owned cars. This mobility gave these staff members the option to leave at any time of the day to avoid the facilitated process of integration. They were not physically stuck in the clinic or day hospital during the day. The 15 minutes' travel required to visit other areas might have been possible in an hour-long lunch break. In terms of not being able to ignore one another, it could be precisely because they are in

one building that they might be able to do this. Staff members knew the service routines and could have easily adjusted their work schedule to avoid other staff members. Thus, Controlled Space ignores agency with its focus on using space for control. Additionally, this discussion of space is only one part of a much more complex picture. The above analysis comes strongly from the perspective of the facilitator exerting power without insight into her motivation. Reasons might have existed for why she wanted to choose a potentially easier site for the pilot integration project.

4.2 Planning the launch

My first meeting with Yvette, after discussing the choice of the site she next explained the planned launch event. She wanted to organise a lunch in the tea room of the Paradise Park facility to launch the pilot project. She had a special caterer in mind who could prepare some very luxurious lunch items. The lunch was to be attended by all the important role players including:

- Dr Davisson (director of the municipal services).
- Dr Cabral (head of the community health services at the South Peninsula municipality).
- Dr Lennox (Western Cape Province chief medical officer for the South Peninsula).
- Area managers from both Municipal and Provincial services.

This was the first event planned for the staff members and the first act of the facilitator. Yvette was central to this first event. She coordinated not only the food and the venue, but she determined who was invited, the structure of the event, and who will speak. Her central role in this event requires a closer look at the role of the facilitator in change processes. Schuyt and Schuijt's (1998) exploration of consultants advising on organisational change provides a framework to do this. They assert that consultants act much as magicians, medicine men or witch doctors do. These individuals realize requests and desires by bringing rain or a good harvest, intervene in misfortune such as

illness, and guide and smooth the transitions of life from birth through maturity and marriage to death. As magicians structure and guide transitions in life, consultants and facilitators structure and guide change process. Schuyt and Schuijt's (1998) views are supported by Gbadamosi's (2005) exploration of consultancy in Botswana, and Clark and Salaman's (1996) discussion of management gurus.

To explore how facilitators as magicians structure facilitated processes we can look, as Schuyt and Schuijt (1998) did for consultants, at the rituals used. Facilitators, like magicians and consultants, seek to sooth uncertainty and anxiety caused by the facilitated process. To do this they, as magicians and consultants, resort to rituals and symbolism. Schuyt and Schuijt relate the change process to the three stages of the rite of passage as defined by Van Gennepe (1960):

- a) Separation: *rites de séparation* (detachment from the old status).
- b) Transition: *rites de ségrégation* (termination of the ordinary, daily life).
- c) Incorporation: *rites d'intégration* (assumption of a new status and the return to society).

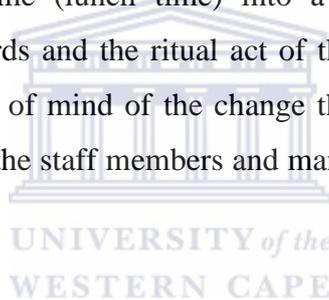


They also quote Malinowski's three elements of magic ritual to guide their discussion of the use of ritual by consultants in the change process, as discussed in Beattie (1966, p.213):

- a) The incantation or magic words.
- b) The rite, the act that is performed.
- c) The spiritual state of the person conducting the ritual, or the ritual state of those about to undergo the transition: free of hate, virginal state, etc.

Clark and Salaman (1996), in their discussion of management gurus as witchdoctors, add that the transference of skills of (particularly) problem-solving is central. These gurus, through words and deeds, are able to transform consciousness or the perception of the problem among managers and staff members.

Considering Yvette as the facilitator/magician and the lunch as a rite of separation, she would have been trying to smooth the first stage of the process particularly since none of the staff had been informed about the start of the facilitated process. Using Malinowski's three elements of magic ritual, this act of smoothing can be seen as follows. Yvette formulated the magic words through her own speech and by prompting some of the words the managers should say to the staff members. She will have wanted the managers to show their unanimous support for this process through their presence and their words. The lunch itself can be seen as a ritual act of the separation. It took place in a familiar space for the staff members: the tearoom. The event was made more special by the luxurious food provided by a caterer. The presence of managers would have added to the special feeling of the event. The launch event turned an ordinary space (the tea room) and time (lunch time) into a special space and time. The combination of the magic words and the ritual act of the lunch put the staff members and management in the frame of mind of the change that is about to take place. This brought about a ritual state of the staff members and managers of the transition that will occur soon.



Using the concepts of rite of passage and the central role of the facilitator raises the question of emphasis: does this way of looking at change processes put too much emphasis on the facilitator? Hislop (2002) suggests this risk in his discussion of the role of the client in the change process. He states a number of metaphors that have been used for consultants, including Schuyt and Schuijt's term of magician. These metaphors might make the client (i.e. management and staff members) seem passive. This critique is similar to that discussed earlier around Controlled Space and the lack of resistance it allows.

4.3 The role of the facilitators

The process is very important and it will be our task to reaffirm how much work the staff has put in, and help them look at the good work they are doing. (Yvette, September, 1999)

A third part of the first meeting with Yvette discussed our roles in the process. It is the first time we met and we would be working together for the entire project. The previous section showed how Yvette carefully considered both the choice of the pilot site and the launch lunch. The quote above is an answer to my question of what my role would be. To set the context for the discussion of our roles, I first look at Yvette's comments and behaviour so far, and consider her motivation.

It is obvious that Yvette put much thought into the choice of the site for this pilot project: having two services in one building and the isolation of the site have the potential to make the project more successful. This choice was actively promoted with the SAHA and DoH. This makes me consider why she did this so actively and whether the key is that Paradise Park was a careful choice in terms of Spatial Tactics. Yvette as an individual can be viewed as a young, early-career woman working in an NGO environment. Yvette would have been looking to establish her reputation in an NGO which has had a long working relationship with the government for integrating the health system. The NGO had varying success with integration pilots, with noticeable failures, particularly in urban areas. Yvette might have been under some pressure to make this pilot a success, to enhance both her and her NGO's reputation. She could have viewed Paradise Park as an easier site and thus more likely to lead to success for the project, and herself.

Another perspective is that by pushing for Paradise Park, she might have felt she could take some control over the outcome of the project. Considering that so many projects had failed, she might have feared that this new project might also have challenges and

would be difficult to implement successfully. This perspective is supported by the way she carefully planned the lunch event. People and their behaviour are difficult to influence and control. The choice of the site and the organisation of the lunch were two features she could control. By using Spatial Tactics and planning the lunch in this way she might have felt she was exerting some control over the outcome of the project. Her words and behaviour showed her as the facilitator/magician who exerts control out of ambition and fear of failure.

This explanation makes her sound very self-centred. However, it is possible that she wanted to succeed for more altruistic reasons: a belief that the change is for the better and will help improve health outcomes. Human behaviour is complex, and it is possible she was motivated by a combination of these and perhaps other factors. The fact that she was a young woman who might have struggled to exert control during the process is another factor to consider. She would have been facing nurses, doctors and managers who are older than her, with two of the senior managers being male. Her need for control might have reflected the lack of control she felt due to her age and gender. The control over the choice of site, which she argued for with the managers, and the control she exerted over the managers in deciding on their approach and speech at the launch lunch, might have been ways of her showing she was in charge from the very start.

Returning now to the quote at the start of this section, and considering Yvette as the facilitator/magician exerting control, requires some discussion about the meaning of this statement. As I said above, the quote is her reply to my question on my role in the project. When I was recruited by my head of department at the University of Western Cape, he explained to me that I was brought into the project as a researcher, a PhD student and a co-facilitator to the process. At that moment, about a week before the launch of the project at the lunch, it was important for me to understand what Yvette (as the lead facilitator of this project) would expect of me. Considering the quote from the perspective of Yvette as the facilitator/magician makes sense, as she will reaffirm the work of staff and help them to recognise their good work. Like magicians, a facilitator puts people at ease and soothes their anxiety and uncertainty. Looking at change

processes from the perspective of someone who exerts control brings another dimension to this quote. Change processes require hard work and sometimes the facilitator will have to deal with confrontation. Although smoothing is required, a facilitator will also have to take on the more unpleasant parts of change processes such as resistance. When Yvette told me that my task would be to soothe anxiety and uncertainty, this implies that she would be the one taking on the tougher tasks of introducing and enforcing change. It might also have been her (as the facilitator/magician) trying to put me in a certain mindset so that she knows what I will be doing and that I will not upset staff members nor will I harm the facilitated process she envisions.

Another element emerges by looking at the quote from the perspective of Yvette as the person who exerts control. Her approach might have been a way of her controlling another aspect of the integration project: myself as the co-facilitator. This can be concluded by considering the combination of her not mentioning the hard work, focussing on my role as one of positive affirmation, and because at that point she was ignorant of how I would act as a co-facilitator. She might have wanted to ensure that I offered only positive affirmation in my role, but not participate in the harder task of enforcing the change. This act of trying to control me is supported by what she told me about my clothes as I left this first meeting. She told me that she feels that I, as the co-facilitator and researcher, should try not to dress like a student. In her eyes, my favourite outfit of blue jeans, flip flops and t-shirts were too reminiscent of student life. Writings in anthropology support her comment and agree that active strategies of impression management are necessary (Lofland and Lofland, 1995, Hammersley and Atkinson, 1995, Coffey, 1999, Warren, 1988). Coffey (1999), for example, highlights the importance of clothing and props such as jewellery as well as demeanour and speech while Warren (1988) highlights how important presentation is for the negotiation of the fieldwork between researcher and participants. I do not disagree with the need to actively manage how I present myself within the facilitated process. However I believe this was an act of control rather than a comment upon my professional conduct for the following reasons. Yvette invited me to her home for this first meeting. Since I knew she was around a similar age and the wife of colleague from the University, I felt confident I could wear fairly informal clothing. The correctness of my choice was

confirmed when I saw she was dressed fairly similarly. If I had dressed more formally, our meeting would have been awkward. Instead I showed professionalism in terms of props by carrying the documentation on the project I had been given and a notepad. I do not think either of us would think that our informal dress at the meeting implied we would dress similarly at the launch event. It did occur to me that perhaps her husband had made a comment on my manner of dressing in general but since I did not dress like this at work, I do not think so. I also think that, considering, that the launch event was potentially quite shocking as staff were to be told that they would be entering a facilitated process, the way that I would be dressed (as a co-facilitator who would say little compared with senior managers like Nelson Davisson) is unlikely to be noticed. Of course, considering dressing at the launch event or any facilitation activity, there is the issue of who one should dress for. Hammersley (1995) points out that strategies around impression management are unitarian. At the launch event, as the whole facilitated process, many different participants from different social context would be present. Each of these are likely to respond to a different identity depending on what they expect of me at that time and place. This makes it difficult to know what the best strategy is. However, that does not mean that the researcher should not consider this carefully. It also occurred to me that dressing as a student, might well have been to my advantage at some moments. It can be used to seem slightly removed from the integration process and not be too identified with it. It can also have the advantage of being allowed to ask stupid questions which a person who is seen as in charge of a process might be expected to know the answer to. I used different strategies depending on who would be present, what I thought participants were expecting of me and what would support my work that day.

4.4 The aim of the Paradise Park Project

The aim of the Paradise Park Project is the integration of the existing clinic and day hospital into a single Primary Health Care facility offering quality health care to the Paradise Park community. (Owens, 1999b)

The quote at the start of this chapter, relating the aim of the Paradise Park project, was formulated by Yvette in the development plan she prepared in October 1999, before the start of the process. I have repeated it above. An aim is a central part of any project as it can be seen to paint the story of the project. By providing insight into the outcome, an aim tells the story of the outcome and conveys a vision of the future. In doing this, it gives shape to the whole process to be undertaken.

Narrative analysis is used here to investigate this story in more depth and to consider the different elements of the aim and how it is used. As Yanow (2000) notes, narrative analysis allows us to look not only at the meaning and who authored text, but also at what the text does not say and what is conflicting. Narrative analysis can also help to analyse the relationship between the written and action.

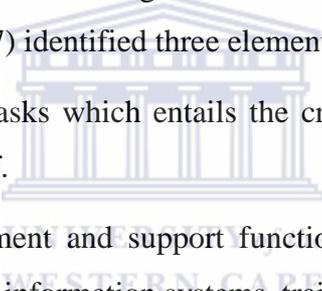
The development plan, where the aim was written, provided a structure for the facilitator to follow, while providing insight into the planned process for both staff and management. Considering the aim from the perspective of Yvette as the facilitator/magician, the aim can be interpreted as smoothing the transition and soothing anxiety by formulating a symbolic final state to the process. The formulation of an aim falls under the first transition in the rite of passage (the separation), where words are used to bring staff members and managers into the ritual state ready to make a transition. The aim is used to convey that the facilitator/magician knows what the end goal is, and how it will be reached.

The use of PHC in the aim is noticeable. This signalled a close relationship between the pilot project and the work of the WHO to achieve comprehensive PHC. Section 3.4 discussed how PHC was promoted in the international arena as an effective approach to provide access to essential health care for all. By referring to PHC in the aim, the impression is given that the project was not conjured up out of thin air, rather it had been considered, defined and designed by specialists, based on evidence. By using these words, the facilitator/magician showed that she was both knowledgeable and capable:

she understood the trends in the international arena and she could apply them to a project setting.

What does the aim not say? The aim included the goal of offering quality health care, but an external focus on including other stakeholders was absent. The aim limited itself to the health-care facility. A conflict was evident, therefore, between including PHC in the aim (which is a very open and inclusive concept), whereas the rest of the aim focused solely on the single health facility and its function of providing services to the community.

However, this internal focus is understandable given that the Paradise Park project was meant to be concentrate on functional integration rather than full integration. The WHO study group (WHO, 1996, p.5-7) identified three elements of integration:

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- a) Integration of service tasks which entails the creation of multi-purpose clinics with multi-purpose staff.
 - b) Integration of management and support functions including planning, budget and financial processes, information systems, training, supervision and research.
 - c) Integration of organisational components which involves the integration of resource providers which operate under various administrative systems, the inclusion of the district hospital, integration of various developmental projects and the integration of health care into the community and family.

The functional integration of the Paradise Park Project excluded elements b) and c). The integration was to focus solely on changing service tasks for the clinic and the day hospital, but not changes in supporting systems including management, administration and finances. For example, administrative and financial structures above the level of the clinics and day hospitals, including structures for salaries and promotion, would remain the same. Thus the written aim predicted the action of the integration process: a closed focus on the functioning of the clinic and the day hospital.

Although the aim focused on the functioning of clinic and day hospital, the rest of the development plan did mention the community. However, this did not represent multi-sectoral involvement as defined under PHC. The development plan assigned particular roles to the community as well as staff and management. These roles will be discussed next.

4.5 The role of managers

[Dr Lennox] is known as Dr No. he will always find a problem.

[Dr Cabral] is enthusiastic about the integration, but she is benign. She does have support from Nelson Davisson and the staff.

At our first meeting, Yvette shared some of her observations of the managers. The two managers identified in the above quotes were the only people she described in detail at our meeting. This suggests that she considered these two managers as the most important people for the project. Since management take a pivotal role in the success of integration projects, her view is unsurprising. The WHO (1996) study group identified managers as a boundary for the success of PHC. Similarly, Wealkens et al. (2002) identified management as a main reason for the failure of integration projects, particularly if two very different management structures were involved (which existed in Paradise Park). Management become even more important if the success of a project depends largely on the service providers (WHO, 1996), as was also the case in Paradise Park. Staff members need sustained support and supervision from their managers to be able to incorporate change into their daily practice (WHO, 1996, Wealkens et al., 2002). Lack of support and leadership have been identified by the SAHA as major obstacles to change in the former pilots in South Africa. Yvette herself identified managers as pivotal to success in a preparation document analysing former pilot projects, written in September before the launch (Owens, 1999a).

Yvette's descriptions of the two managers suggested contrasting characters. Dr Lennox was identified as likely to bring negativity to the project and to obstruct by finding problems instead of solutions. Dr Cabral, however, was identified as supportive, enthusiastic and having the support of staff members. Such qualities should be positive for the change process. Yvette's use of the word benign, therefore, is puzzling. Benign can be interpreted as being of a kind disposition (like a benign king) or as gentleness (such as a benign smile), or being favourable. These interpretations would match with Yvette's assertion that Dr Cabral was enthusiastic. However, since the word benign was used as opposing enthusiasm, a different explanation is likely. The word benign, particularly because of the medical context of the project, brings to mind the connotation of a benign tumour. Such a tumour is not usually dangerous, does not come back or spread to other parts of the body. Combining this connotation with two synonyms of benign (superficial and complacent), a different impression emerges. It felt as though Yvette wanted to convey that Dr Cabral would neither harm the process intentionally, nor exert herself to make it work. The facilitator/magician, therefore, would need to handle carefully both these managers and the staff members who might be exposed to Dr Lennox's (Dr No's) obstructive attitude and Dr Cabral's benign attitude. The importance of choosing Paradise Park as a site also was evident. Controlled Space means being able to control when the managers visit and thus being able to control partly their influence over the process.

4.6 The role of Paradise Park staff

The district has therefore decided to carefully and sensitively undertake the integration process with an awareness that successful integration rests, not merely on the technical skills and management will, but, crucially, an engagement with staff's needs, interpretations and ideas. (Owens, 1999a)

As mentioned earlier, Yvette's September, 1999, document analysed former projects to identify the factors causing failure. This document produced the above statement on engagement with staff. Although management have a pivotal role in the success of a

project, much of the work would be done by the service providers. The development plan, written a month later, unpacked what is meant by engagement with staff. It stated that staff need to participate in how comprehensive care is to be achieved and provided (Owens, 1999b). This statement suggested that staff would take part in providing both the practical content and the decisions on the process of integration. The following elements are included as elements the staff should engage in:

- The faculty's identity.
- What does quality PHC care mean for the Paradise Park community? How do we make it better?
- Types of services to be integrated and how (e.g. drug management and provision of comprehensive care).
- Forms of joint facility management and leadership.
- Forms of joint staff supervision.
- Forms of staff support and development.
- Facility communication and joint meetings.
- Training needs associated with new tasks or roles.
- Methods of ensuring meaningful community participation.

From the facilitator/magician perspective, this list of elements was meant to soothe and clarify what is expected of staff. Including the phrase “comprehensive care” once again signalled PHC rather than a selective approach, showing the facilitator's capability. Using the word “participation” suggested the process would not be prescriptive but would be flexible depending on needs, interpretations and ideas (as identified in the project aim, quoted at the start of this section). To emphasis this point, the facilitator wrote:

the integration is not something that is “done to you”, but a creative process in which you are co-planners. (Owens, 1999b)

The narrative analysis of the project's aim established that the project had an internal focus with an aim to serve the community. The above list similarly reflected this internal focus. The list, with its promise of participation, almost seems to provide a list of actions. For example, the third element describes the types of services to be integrated. On first reading, this element suggests that staff will have a say in which services will and will not be integrated. However, the element includes in parenthesis two examples that cover all the health services provided at Paradise Park. All service tasks will have to be integrated to provide comprehensive care.

A further question that needs considering is how much power staff really had to make changes? If staff did participate and developed different solutions to comprehensive care, would they have the power to implement such solutions? This was very unlikely. The phrase of engagement with staff needs therefore sounds more like the magic phrase of the facilitator/magician. The phrase suggested staff would be consulted and their needs would be considered. However, the reality was that comprehensive care must occur. This made me wonder if the facilitator/magician's words were meant only to soothe, or whether they were using legerdemain (sleight of hands). The facilitator got staff to focus on participation, but at the same time change happens irrespectively. Misdirection is the most important component in sleight of hand. The magician carefully choreographs his or her actions to draw the eyes of the audience away from what he/she is really doing. The next chapters will clarify how much this occurred in the facilitation of the pilot integration project.

Considering the list of elements as a whole, I am reminded of the discussion on nursing practice (see section 3.4). Given the high workload of staff, would they be able to incorporate the additional demands of the change process into their daily practice? The envisioned emphasis on prevention (which includes greater community participation) requires discussing how staff would broker this change with the community and how indigenous health practices would be included. There are then the underlying issues of how nurses in particular view their own jobs and how the community views the jobs of nurses. Chapter 3 highlighted not only a devalued status of nurses but a community

angry about under-employment of local staff. These issues will need to be acknowledged and considered carefully by staff in the change process.

4.7 The role of the community

The needs of the community need to be seen as the reason for the health service's existence and the motivation for our efforts. (Owens, 1999b)

This quote epitomises how the community was recognised in the planning materials. Once again that internal, isolated focus of the project was shown, with the community receiving services. The project's aim stated that the facility would be "offering quality health care to the ... community ... [and] ... the community to receive quality PHC care". The list of tasks included "methods of ensuring meaningful community participation". As discussed under the aim, using narrative analysis, these activities were inconsistent with the concept of PHC in which community participation should be more involving. If actively pursued, engaging with the needs of the community and using methods to ensure meaningful participation could be very positive. However, two issues are noteworthy. One is whether staff would have had the capacity to do these tasks. As noted by Jewkes et al. (1998), additional tasks for nurses are challenging, given their already high workloads. I would add to this, as I noted in section 4.6, staff would need certain skills to be able to effectively engage with the community. These skills were lacking when the project began. The second issue is that the needs of the community in the above quote are the "reason for existence" for the health service. This is a different perspective to seeking out what the community might need. I interpret this perspective as a Florence Nightingale type of calling to nursing. It was aimed at the staff rather than the community, and as such, it failed to make any statement about the role of the community.

The above quote and analysis suggests that community participation would have occurred in the project only in a limited manner. However, it is useful to look at how

community participation has been defined historically for three reasons. First, the project was linked partly to PHC, which should give the community a central focus. Second, the community was mentioned in the project documents and staff were identified as key to bringing about community participation. Third, a real community would have been affected by the changes from integration. The discussion below will show that needs are not central to the definition of community participation. Rather, the definition focuses on involvement (a task staff would be responsible for, according to the development plan) and personal responsibility.

The WHO (1996) study group on integration of health services defined community participation at both a policy and community level. Community participation, in relation to the pilot project, pertains to two distinct roles for the community. First, community participation would have meant taking an active role in the health services, including the planning and implementation of comprehensive services. This would have included involvement in the creation of the integrated services by partaking in planning and decision-making processes. The WHO study group recommended this occurs through creating committees, boards or using existing councils comprising of community members. Second, community participation means community members taking responsibility for their own health. This is embodied in the notion of “community action for health”, which refers to community and family responsibility for health and self-care (WHO, 1996). To achieve full community involvement, partnerships with the community are needed, while also creating health consciousness in people and families to give them responsibility for their own health. Relationships should be built with schools, work places and homes through processes of preparation and mobilisation, which are part and parcel of a holistic approach to the integration implementation process (WHO, 1996). However, these concepts seem absent from how the community was included in the pilot integration project.

Could the staff in the pilot integration project have implemented this fuller package of community participation activities? As noted in Chapter 3, several issues would have hindered this, including the issue of the level playing field, how coloured people were

perceived and its effects, and the community's view of outsiders. Overall trust was low in the community. The community was a very complex role player and much more unpacking would have been needed to involve them meaningfully and in a way that they would have wanted to be engaged. As stated above, I doubt whether staff had the skills and time to accomplish this. However, the focus of integration (as explored in section 3.4) was on the first of the three elements of integration and the community, whereas multi-sectoral involvement really only was included as a third element.

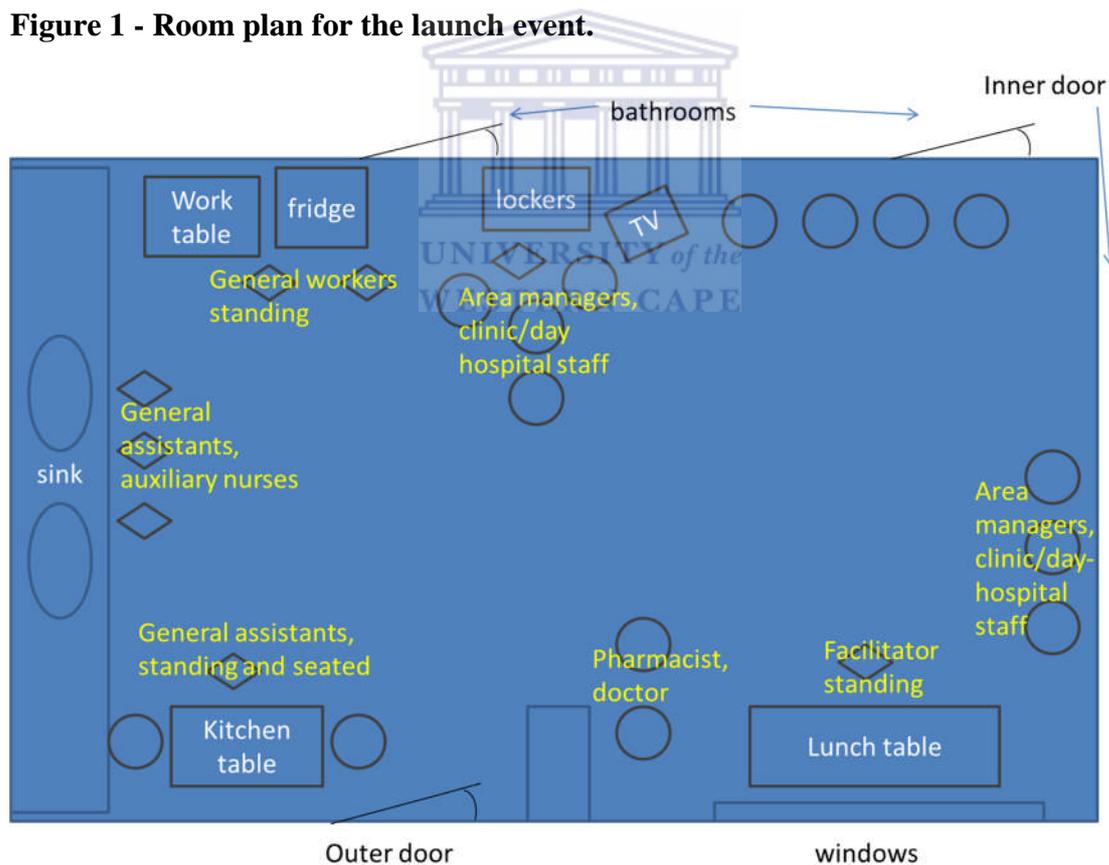
4.8 The launch

On the day of the launch, the caterer arrived at the same time as Yvette and myself at the Paradise Park health services building. Yvette and I helped the caterer set up the table in the tearoom with luxurious food. The room had two distinct sides: the right side of the room was like a living room, looking welcoming with a television, chairs and carpet. The left side was like a kitchen with a sink, fridge, worktables and floor tiles. We set up the lunch on a table in the living-room area. We first covered the old wooden table with white table cloths, with large silver serving-dishes on top. Plates and cutlery were placed on the table to facilitate a running buffet: staff could start at the left and work their way to the right from appetisers to desserts. These arrangements turned this ordinary room into a special time and place (as highlighted in section 4.2, a requirement for the ritual act of separation).

We had very little contact with the staff during this time, even though they were walking in and out of the room. I noted an air of apprehension. The managers from all three levels (executive, intermediate and area) arrived soon after and they milled around, in and out of the tea room, talking to different people. Their demeanour was one of support and their presence showed the specialness of this event, as part of a separation ritual. The managers enquired how people were, how their work was going, and if any issues needed to be addressed. Yvette had been full of nervous tension since we arrived. She was concerned the event was behind schedule. At the agreed starting time, the day hospital staff were all seated, but not all of the clinic staff had arrived.

These staff had looked into the room now and again, but they were still working with patients. Yvette got very upset about this. She complained to me that she had told them what time the event started, and she expected them to be present. Once the clinic staff arrived, Yvette encouraged people to eat. While the staff and managers used the buffet, Yvette and I were encouraging and welcoming. However, we did not eat ourselves, in line with our facilitator/magician role. While in the buffet line, the staff remarked on the quality of the food and asked questions about some of the items. This was not their ordinary kind of lunch. After having selected their food, the staff members chose places to sit and eat. The doctors, management, area managers and the pharmacist settled in the living room area. The lower staff were either sitting or standing in the kitchen area (Figure 1). I commented in my field diary how this seemed highly hierarchical.

Figure 1 - Room plan for the launch event.



Once all the staff members had had a chance to eat, Yvette started the meeting with a speech introducing the pilot integration project. She emphasised the unique opportunity, the element of facilitation, and that this pilot would be addressing an issue that made all the other pilots fail; that is, staff consultation. She chose to stand in front of the food table. Consequently, she was facing mostly the managers and she could not see some of the staff who were sitting in the kitchen (see the room plan) without leaning or stepping forward. In my head, I was shouting at her: “Why does she not stand where I am?” From my position in the middle of the two areas, in front of the lockers, I could have seen and included everyone with eye contact and body language (see diamond shape in front of lockers for position in figure 1). And if she chose to stand there for good reason, why did she not periodically step forward? She was an experienced facilitator: she knew how to use her body and her eyes to make contact with everyone. When Yvette had finished her speech, she introduced me as a lecturer from the University of the Western Cape and said I would be involved in the project. She then invited each of the managers to introduce the pilot integration project. The managers, each in turn, repeated what Yvette had told them to say, ensuring a unified front i.e. this was a unique opportunity, the whole country would look towards Paradise Park, the solution was known, and staff consultation would be prioritised in this facilitated process.

Dr Cabral introduced a change to her prepared speech. On behalf of all staff, she said goodbye to one of the area managers from the provincial management team and she welcomed another to the team. Yvette then ended the official part of the lunch and invited everyone to have some dessert.

The speeches emphasised that the cure for failed projects was known to the facilitator, she was capable of leading this project and she would be able to transfer these skills to the managers and staff members. This was the conscious transformation Clark and Salaman (1996) discussed. The transference of skills of (particularly) problem-solving is central here and the facilitator/consultant asserted, through words and deeds, that she

could transform consciousness or the perception of the problem among managers and staff members.

Yvette's careful preparations as facilitator/magician were evident, just as planned. The launch signified that a change is about to happen, but by carefully orchestrating the pilot project events, such as the launch, the change seemed less sudden or jarring. The planned change was, of course, purposeful and would undoubtedly entail confrontation and conflict. However, by using careful and diplomatic facilitation of change, the pilot project was meant to happen without being too suddenly shocking to the organisational cultures of the clinic and day hospital.

Several behaviours seemed out of kilter with this careful orchestration: Yvette's nervousness, her placement during her speech and Dr Cabral's goodbye and welcome. It was unsurprising that Yvette was feeling nervous about the importance of the success of the pilot project. However, she seemed to focus on relatively small issues. The choice of food, the dressing of the table or my clothes were not going to affect the eventual success of the pilot. Is it because she had control over these issues, unlike the envisioned large-scale change of the pilot project? Her upset about the clinic staff being late (albeit for a good reason: still seeing their patients), showed her lack of control over the whole situation. Her positioning during her speech could have been because she was so nervous, and she froze.

However, why did she stand out of eyesight of the staff members in the kitchen area? These staff were on the lower rungs of the organisational hierarchy. This choice was a rookie mistake unexplained by Yvette's nervousness as she was an experienced facilitator. Given that the launch was planned by her in detail up to this point, it seemed she chose her position intentionally. So why did she stand there? She seemed to be addressing her speech to the managers and in particular Dr Nelson Davisson, Dr Lennox and Dr Cabral. She was aware that the managers, and Dr Lennox in particular, still needed to be convinced of the need for this process. Recalling her explanation of the

managers' characteristics at our first meeting, Dr Cabral seemed very much on board with the pilot project. So could Yvette have been addressing Dr Lennox in particular? Was she trying to convince him to cooperate in the decision-making process at the management level? Since the process favours management by the local authority at the end of the process, Yvette might need him in particular to give his support to Dr Cabral. The problem was that her body language was in direct juxtaposition to her words on staff consultation. This contradiction could cost her dearly when she needs to run workshops and make actual changes.

Dr Cabral's addition to her speech was remarkable as it interrupted the flow of the (otherwise, well structured) launch. Perhaps she was less benign than Yvette imagined. However, as the local authority was run on a more personable basis (as will be discussed in section 5.1), this interruption was understandable. Strangely, the departing manager worked for the province, rather than the local authority. Also, the incoming was never involved again in the integration process. It seemed unlikely that Dr Cabral would have wanted to discredit the process. She had publically given her unequivocal support, and the process favoured local authority (i.e. the management of the district health system). She might have intended her speech to make her stand out clearly from other speakers. She wanted the audience to know that she was there and to notice her. She wanted staff members and the other managers to know that she would be the central figure in this process. Perhaps she was positioning herself to claim credit for the expected success of this process. This would have enhanced her already good reputation and status within the health services and the health department. Whether this interpretation is correct becomes clearer in Chapter 5 in which the role of managers is discussed.

4.9 Staff response: "We have been here before"

We've been doing the integration for the five years. (My field notes, 1999)

After the official part of the lunch ended, Yvette and I collected some food and sat down among the staff. I sat down next to the pharmacist. The pharmacist was a woman in her mid-forties from a white Afrikaans background. She asked me what I was doing here. Yvette had introduced me as a co-facilitator and researcher for the process, but she had not provided any details. I explained my involvement in the pilot and that I would be researching the integration. I talked about being a lecturer from the University of Western Cape, and my dual role as a co-facilitator and observer of the change process. In response, the pharmacist said, in a dismissive manner, that they have “Been doing the integration for the five years”. I felt a need to justify my involvement further, to be accepted by her and her colleagues at the start of the process. I added that I will be also looking at the patients. She refuted this by commenting that “there is only one answer to this: poverty”. Obviously, she was unconvinced that research needed doing. No-one could change poverty quickly. She might have been telling me that the process would fail because poverty affects people too much. For example, poverty meant that people could not take care of their nutrition and hygiene, or they have to sell their own medication. Such a fatalistic view of health implies that health and other services just provide a temporary patch to the bigger ailment that poverty brings.



Then, I asked her to point out a few people in the room as I did not know everyone very well yet. Coming to a visiting female doctor, she states: “That little one is from Nigeria.” This was in contrast with how she addressed Dr Uys²⁷. She was always addressed as doctor both in a personal exchange with her or in conversation about here. No diminutive was used in relation to her. The use of doctor in this way can be seen as a mark of respect (a similar case is discussed under section 6.2 Expected Outcomes Integration – clinic manager). In the short time that she was at Paradise Park during the project, I came to know her as quite disparaging to people of other races, Black or Coloured in particular. For example, I have heard her comment on how people could at least have a wash even though they were poor, how the community members were almost all criminals and had tried to break into her pharmacy several times, how the patients coming to the clinic and day hospital could not be trusted as they would try to

²⁷ Dr Uys is the GP at the day hospital and will be introduced in table 3 chapter 6.

either get more medication than they needed or try to sell medication. She would comment on how her colleagues from Paradise Park could not be trusted to do their work properly without supervision. That they were lazy and would try to get out of tasks. Her comments were sweeping and felt without context. Section 3.3 discussed how such comments are unsurprising, given she was a white woman who grew up under Apartheid. Her comment might also have reflected a general dislike of Nigerian people which climaxed in the xenophobic attacks in South Africa in 2008. I think she felt we would share this view, given our common race (White) and educational level. She then asked if I would like to see the pharmacy. I was glad for the distraction, as her racist comment clashed with my personal values (discussed in section 3.6). Unsurprisingly, I took an instant dislike to her. Although she played a minor role in the pilot, this dislike stopped me from asking her too many further questions on this occasion. This is of course a limitation of my research as she might have had a valuable opinion to add to the process particularly in relation to the discussion below in terms of the place of the pharmacy. I, of course, did not make a habit of avoiding people I disliked in the facilitated process. If the pharmacist had been present for the entire process, I would have had to face these feelings, as I have done with other participants.



The pharmacy was situated in between the waiting room and some of the clinic rooms. It was a fairly large rectangular room. One door led into the room from the corridor between the waiting room and the treatment rooms on the short side of the room. A hatch to the waiting room was placed on the long side of the room. The other short side of the room was the outside wall. The room had no windows. The walls were filled with bottles, boxes and other pharmaceuticals, carefully and systematically organised and labelled. As the only room in the building with air conditioning, it was very cool. The door was kept locked, and the pharmacist locked it behind us as we enter. The room felt quite isolating to me. No one could enter without knocking. Interaction was done through a hatch which only the pharmacist could open and close. The hatch was quite low so the pharmacist had to bend down to use it in the short time every day that the pharmacy was open for dispensing. The lack of windows and the hum of the air conditioning meant that the person inside cannot see or hear what is going on inside or outside the building.

It occurred to me that pharmacies are central and special spaces in health centres. Health services of all levels need pharmacies. A pharmacy has to be run by specially trained pharmaceutical staff. Pharmacies need arrangements such as air conditioning and security measures. Once in place, therefore, pharmacies are fairly unmovable. In an integrated service, pharmacies are comprehensive in nature as they dispense to all patients with a prescription.

The pharmacist doubted the integration process and she was very bold and up-front about it to me, who was so closely connected to the process. It occurs to me, she might have felt above the process. Consider her background: she was white, well-educated, and middle-aged. She was working in a Coloured community and her comment about the Nigerian doctor implied she lacked sympathy for their needs. Running the central and special function of the pharmacy, she was in a strong position. The health system had a shortage of pharmacists, Therefore it was unlikely she would have lost her job or be offered a lower salary or a worse job package in the integration process. Her job security and status, therefore, help explain her boldness to me.

4.10 Five years of integration

The comment from the pharmacist on a five year history of integration is intriguing. The history of integration was discussed in section 3.4 and it will be summarised here for clarity. The pharmacist's comment was correct for two reasons. Firstly, the first major change to the health system was introduced in 1995 with the district health system policy document policy soon after the first democratic elections in 1994. This was intended to address the major inequalities inherited from the Apartheid era. This document made a link to the local authority as the one to take charge which I mentioned earlier, and will be explored further in section 5.1. The report highlighted that accountability, community participation and local health needs are easier to address from the local level. However, local authorities need sufficient resources and capacity

strengthening to take over this role. The decentralisation of administrative systems then was legislated in the new constitution of 1996. The White Paper of 1997 (Department of Health, 1997) outlined the transformation of the national health system. Since the first document, the district-health-policy document, efforts have been made to integrate the health system, now under provincial and local authority, into one system. However, as far as I was aware, Paradise Park had not yet been involved in the process.

Second, a physical change to the Paradise Park building helps explain the pharmacist's comment. Five years before the comment was made, the building changed dramatically as the wall separating the clinic from the day hospital was demolished. Since then, the staff was encouraged to work together and share resources in accordance with the district-health-system-policy. Referrals between services improved. Examples included the referral of dressings from the clinic to the day hospital, referral of tuberculosis patients from the day hospital to clinic, and referrals from both services to the paediatric doctor or the mental health nurse. Although the clinic had its own small drug store for common childhood ailments and family planning, sharing of the pharmacy was established. Overall, therefore, financial resources were shared to some extent. The use of the space changed also from the patients' perspective, as they now entered the building through one main entrance and registered at the same reception counter. Separate waiting areas for children, family planning, day hospital, and tuberculosis were maintained but close to each other in the shared corridor.

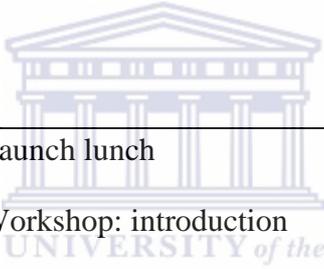
4.11 Conclusion

This chapter has described a carefully planned process, focussing particularly on the facilitator/magician's role. She carefully chose the site for integration, carefully prepared through analysis of failed projects, considered the key players and planned a launch event to detach the staff from their old status. Space and narrative analysis were used to analyse the elements of the project's planning. These elements form the basis of this pilot project with a central facilitator as magician and her use of Controlled Space.

In the next chapters, I will unpack the facilitated process from all the role players identified in this chapter:

- The managers, who have been identified as pivotal for success.
- The facilitators, who will lead the process as magicians.
- The staff, who will be making the changes.
- The community, who should be given a meaningful way to participate during the process.

Yvette planned workshops and meetings for different points during the process. These events did not all occur. The timetable for this process is shown in the text box below to help inform the next chapters:



7th October, 1999	Launch lunch
11nd November, 1999	Workshop: introduction
20th January, 2000	Joint planning for the district
2nd March, 2000	Integration meeting
27nd March, 2000	Staff meeting
1st June, 2000	Workshop 1
1st March, 2001	End of project
14th March, 2001	Joint planning for the district
June, 2001	Project evaluation meeting

This overview will help to clarify when certain events happened as they are discussed in the next chapters. The fact that Yvette was not able to execute her plans is of course significant in itself. This will be discussed in the next chapters.

Chapter 5 - The role of managers in the integration

At the start of the Paradise Park Project on 7th October 1999, the managers showed their unanimous support, albeit partly coached by the facilitator/magician. This was a good start for the project, particularly because the literature ascribes managers a pivotal role in the success of integration (WHO, 1996, Wealkens et al., 2002). However, Chapter 4 showed Yvette had doubts about the continued support of the managers for the facilitated process. She thought that Dr Lennox might bring obstructions; and Dr Cabral might be supportive but not exert herself to make the project work.

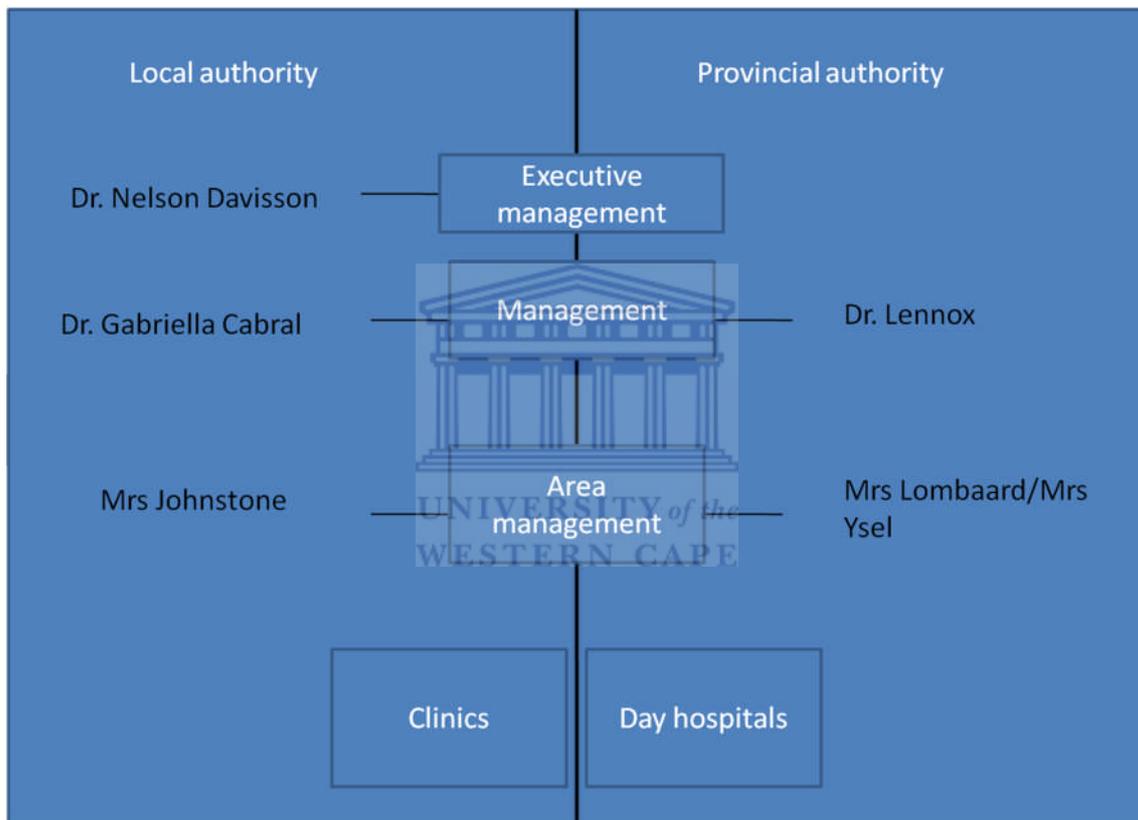
This chapter analyses the role of managers. I focus particularly on Dr Cabral and Dr Lennox, the two people expected to play an active role in the process. Also, a shift of authority at the end of the integration process would favour the local authority, which Dr Cabral manages. I will show that Yvette's doubts were well founded, although perhaps not for the reasons she identified initially.

To illustrate this change in support from the managers, I will focus on a meeting that took place on the 2nd March, 2000. At this meeting, only five months into the project, something seems to shift. The managers disappeared from the process, as if they did not want to commit anymore. I will explain why this occurred, and its effects on the project. To support this analysis, narrative analysis again proved very useful. Since much of the negotiations between managers and Yvette occurred in my absence which is a limitation for the level of analysis in this chapter, it is revealing to consider what was said in the public arena. I found Scott's (1990) concepts of dominance and resistance very useful to understand staff and managers' responses to the facilitated process. As managers are in charge of health services and essentially give the order to integrate, the concept of dominance is relevant. However, I will show this presents a binary and over-simplistic view of power relations. Staff responses to the process will be discussed in the next chapter.

5.1 Leadership styles

Fundamental to understanding the role of managers is differences in leadership styles. As noted in Chapter 4, leadership styles were vastly different in the municipal and provincial authorities. Figure 2 below summarises the hierarchy of the two authorities:

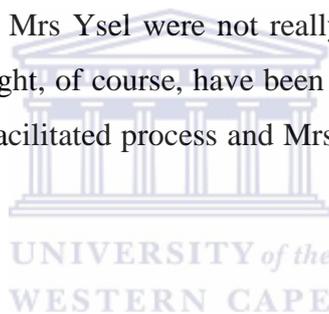
Figure 2 - Organogram of provincial and municipal authorities



The difference in leadership styles was most evident in how Dr Lennox and Dr Cabral were addressed. As I just wrote, most people, including her staff, addressed Dr Cabral by first name; Gabriella. During my three years at Paradise Park, Dr Lennox, was referred to by his first name only once, by Dr Davisson who is more senior the hierarchy. Area managers are nurses who had progressed through their organisation to take this more senior role. Their status is indicated by their address changing from Sister to Mrs The more personal style of the municipal services was evident at this level. Mrs

Johnstone was well liked by the staff of the clinic due to her closer involvement: she phoned and visited regularly. She was perceived as always available for any staff members at any level who needed her. This was evident in the meetings she attended, by statements such as “I realise/notice this is missing/needed. I will organise it for you”.

Mrs Lombaard and Mrs Ysel were not generally involved in the daily running of the day hospital. This role was decentralised to the nurse in charge of the day hospital, or failing that, the doctor at Paradise Park. Apart from area meetings, these managers were not usually present at day hospitals. The area managers are based at an administrative office in the southern suburbs of Cape Town about 22 km from Paradise Park. I am unclear about how these provincial area managers were seen both by the day hospital and clinic staff members at Paradise Park. That is telling in itself, since I was around for about three years. Mrs Lombaard or Mrs Ysel were not really present during the process of facilitated integration. This might, of course, have been because Mrs Lombaard left the service half-way through the facilitated process and Mrs Ysel was relatively new to the job.



5.2 Expected outcomes from integration

The answer to surviving all these transformations is to see them in terms of a business plan with a clearly defined mission and strategy. The solution is to focus on what the two sides have in common, rather than the differences (Dr Cabral).

They tell us to use human resources more equitably, more efficiently, more rationally but that is utter nonsense. We’ve been doing that for six years and it didn’t work. We’ve tried all the combinations and permutations and nothing is helping us. Dr Lennox. (SAHA, 1999)

These two quotes were collected two months before the facilitated process started. Both quotes reflect Yvette’s observations of Dr Cabral as being supportive and Dr Lennox as basically saying “no”. For me, the quotes are most striking because of the extreme

opposites they present: very positive and upbeat versus negativity and almost defeatist. By exploring these quotes through narrative analysis a fuller picture of the manager's motivations and behaviour emerges.

Both managers were medical doctors who had taken positions of leadership: Dr Cabral for the municipal authority and Dr Lennox for the provincial authority. Both managers might have struggled to access education during the Apartheid era due to their backgrounds (non-White), but both prevailed. One of my limitations for the thesis (see section 3.6) is revealed as I never had the opportunity to ask about their backgrounds. This means that I might not know if either doctors or their families were exiled at any point during the Apartheid era which might have had an influence on their access to education and job opportunities. It also means I do not know if either one of the doctors belongs to a higher class or elite class which could also have influenced their access to education and job opportunities. One possibility is that Dr Cabral was of Portuguese descent. As discussed in section 3.3, she would therefore be classified as mixed descent rather than Coloured. However, this background might have caused her problems, as Western (1996) notes that Portuguese were not accepted as real Whites. Her gender might also have caused problems as section 3.4 and the discussion of the nursing profession as a gendered profession has pointed out. For Dr Lennox, I can only guess his background. Similar to Dr Cabral, even if he was not of mixed descent, the way he looked would have caused him to struggle in education.

The reference to a business plan in Dr Cabral's quote is intriguing. This might reflect the training managers inevitably undertake. Alternatively, does the reference reflect a more business-oriented perspective on health services in South Africa? I think Dr Cabral might have wanted to present herself as business-like; that is, taking a structured approach, getting things done and not getting stuck in minutia. This interpretation was supported by the views given by her colleagues. Both staff and management throughout the district viewed her as a champion. Yvette and her NGO have made statements about Dr Cabral's champion status. Every project Dr Cabral supported so far was perceived as having succeeded. She was most known for her involvement in interventions to reduce

tuberculosis. Her presentation on 14th March, 2001, to the district stated that the tuberculosis prevalence in the Western Cape was the highest in the world, and an 85% cure rate was needed to bring the disease under control. The clinics under her management reported a 100% cure rate without interruption. As a reminder, Yvette's project aim referred to PHC to make her look capable (see section 4.4). Similarly, Dr Cabral's reference to a business plan might have reflected her wanting to show that she was capable of leading this process, and ultimately the district health system.

Dr Lennox's quote on the expected outcome at the start of this section, however, showed him being negative and obstructive, as predicted by Yvette. He did not even seem to contemplate that the process could succeed, although positive outcomes have occurred elsewhere in South Africa. Similar to Oliff's (2003) findings from Tanzania, his response could be due to his fear of losing power from the changes of integration. It was planned that the municipal authority would take the reign on the district after the integration. Where would this leave Dr Lennox? Any change to the power of such an important role player could prompt a negative reaction (Hunter, 1992, Weiss and Fitzpatrick, 1997). Obstructionism, therefore, could be in his best interest. By not cooperating, the project falters and the status quo remains with him maintaining a strong management position.

It then occurred to me that being perceived so negatively cannot be good for Dr Lennox's career either. So I wondered if the explanation for his obstructive approach also reflected the lengthy process Dr Lennox referred to: six years is a long time to work on integration without seeing any changes. He would have been aware that staff shared his view²⁸. So did he think that the integration project was following the wrong process? This interpretation is supported by the part of his statement that "nothing is helping us". This does not sound like a statement from a person who does not want improvements to happen. It also does not sound like a person who does not believe that the current way of working is most beneficial for staff or patients. It seems to me that he thought that the

²⁸ A similar comment was made by the pharmacist at Paradise Park (see section 3.9).

“combinations and permutations” tried previously did not work, and the Paradise Park project would similarly fail. He might have had the best interests of the health services at heart and wanted to occupy a position of power to shape the future of the health services (Hunter, 1992). If so, his strategies are an example of a hidden transcript by a dominant role player. These strategies mean that Yvette was indeed right that Dr Lennox would be obstructionist, but his reasons might have been more complex than just find[ing] a problem, as Yvette was quoted as saying in section 4.5.

5.3 Two managers, two authorities

We wanted to appoint someone on the inside as the clinic manager and wanted to open up the position to both [the provincial authority staff] and [municipal authority staff]. It is so difficult. [The provincial authority] do not want to pay. We have tried different constructions. If the manager is chosen from the [provincial authority] side, Municipal administration offered to take them over but that meant they would lose their benefits. Which would not be a problem for someone who has just started but for someone with quite a few years it is very important. Municipal administration offered to top-up the salary of the provincial authority manager but provincial authority said “No”. (Dr Cabral)

Up until this point, the facilitated process had been going smoothly and to plan. The launch was mostly successful, with managers showing their unanimous support. Yvette then coordinated the first workshop for staff to discuss their feelings, problems and fears. This took place on the 11th November at a beautifully situated venue called Little Stream in the relatively rich suburb of Constantia. Given the workshop focussed on staff, it will be discussed in the next chapter. The new year started well with a joint planning workshop for the whole district on the 20th January. At this first joint planning meeting, both Dr Cabral and Dr Lennox were present and took an active role. The goal of the day was to develop priorities for health for the district. The participants were divided into groups according to topic, to work with a facilitator. I was a facilitator and I took a group on community-related problems to a break-out room. Both Dr Cabral and

Dr Lennox led other groups. Taking these active roles showed clear support for the overall process of integration.

The meeting on 2nd of March at Paradise Park should have continued this support. Dr Cabral's quote from the meeting at the start of this section made me question why she raised these issues publically. I also wondered why Dr Lennox seemed so against the idea of appointing a clinic manager, and the implications for the process. This meeting marked a turning point in the facilitated process. The perspective of the managers on the facilitated process is discussed below, whereas the perspective of staff will be discussed in Chapter 6.

First, it is important to recount the start of this meeting which bathed the proceedings in negativity. The meeting begins with confusion around the start time:

Mrs Lombaard (provincial authority) and Mrs Johnstone (municipal administration) have organised this meeting but there is a lot of confusion and anger about the time mix-up. Yvette tells me the meeting starts at 13.30. When I phone Mrs Theron at the clinic she says she has been told 12.00. But when I arrive with the cake around 11.00, I find out it will be 14.00.

13.30. Dr Cabral arrives. She is ticked off because the meeting is now at 14.00.

13.45. Dr Davisson calls to say he is on his way.

14.15. Everyone is sort-of here and the meeting starts. (Fieldwork notes)

In the 45 minutes before the start of the meeting, Dr Cabral walked around and kept talking, angrily, about the mix up over time. At 14.15 everyone had arrived except the general workers (these three members of staff will be introduced in the next chapter; one of their responsibilities is cleaning the building) and Dr Davisson. Neither Dr Davisson nor the general workers arrive during the meeting. The meeting then started with Dr Cabral immediately taking the floor and stating:

We are not impressed with the confusing messages. I spoke to Mrs Johnstone and it should be coming through on paper form from now on to confirm these meetings. I am not going to chair this meeting. (Fieldwork notes)

Even on paper, Dr Cabral's attitude comes across as aggressive. An interesting question is to whom is she referring to as we? Considering that Mrs Johnstone and Mrs Lombaard organised the meeting jointly, Dr Cabral could be referring to all the invitees. Alternatively, she could have meant we as those participants who had to travel to attend (i.e. Dr Davisson, Dr Lennox and herself). This interpretation is likely, given the staff from Paradise Park were present in the building already and a change in meeting time would only interfere slightly with their daily routines. Such a statement gives a highly hierarchical message - i.e. managers are important people who cannot be inconvenienced by confusions like this. Yvette then continued to say that she has already solved the problem by speaking to Mrs Johnstone to ensure it would not happen again. She portrayed herself as annoyed but still capable of sorting out issues. Similar to the statement of the expected process of the business plan, she showed herself as someone who can structurally solve any problems that arise.

Dr Cabral's next statement that she is not going to chair this meeting is a little strange, since no-one really expected her to take this role. Chairing would be done by the meeting organisers (Mrs Johnstone or Mrs Lombaard), or, since it was an integration meeting, Yvette. Dr Cabral might have been signalling that she does not want to take part in the meeting. However, Dr Cabral makes an interesting statement just after the meeting begins about the clinic manager (see above at the start of this section). This statement does a number of things. The statement firstly, considering the integration as a whole, brings up issues of how the process is going to work in practice. The above quote, at the start of the section, is an example of a decision that has administrative and financial implications, that requires negotiation between the two authorities. Appointing a clinic manager for both services could be interpreted as a step towards integration, but this brings up the issues of benefits and salaries. It made me question how easy it is to

try and isolate an integration project from the overarching issues that were affecting both services, and thus how feasible functional integration is on its own.

Secondly, Dr Cabral's statement shone a light on the struggles between the two authorities behind closed doors. Knowing that eventually only one authority would exist, the managers are required to negotiate. By bringing this issue into the open, Dr Cabral appeared in a problem-solving capacity whereas Dr Lennox appeared obstructionist, as everyone was expecting. Dr Cabral is portrayed positively and wanting to help the process along, but also as unbiased as her suggestion is open and equal towards both services. From the analysis of Dr Lennox's perceived obstructionist point-of-view, his refusal to support this idea is better understood. However, the explanation is more complex if his reluctance was caused by him believing the process was incorrect. Considering Dr Lennox's response might determine which interpretation was more likely.

After Dr Cabral's statement, Dr Lennox replied by giving a lengthy discussion about functional problems. He then stated:

All that eating at Little Stream etc. is so far, but the problems are here. So now what?

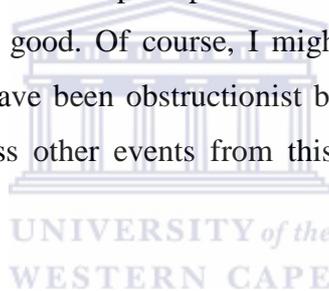
His lengthy reply seemed to soothe, in a way. I could not remember any real details of his reply, but I remember feeling a little bored and noticed others' expressions glazing over. Considering the anger that could be sparked by his seeming refusal to help put a clinic manager in place, boredom as a response might be preferable. One possibility is that he might have been explaining that functional integration does not work. By referring to the first staff workshop he turned the conversation away from power-play between managers, towards the facilitator, who organised the meeting, and the staff, who are to make the changes. As we shall see in the next chapter, his point of view echoed what the staff were thinking and voicing. He was asking, as they were, how the process will be taken forward. This approach cannot be interpreted as him being

obstructionist and refusing to support the idea of a clinic manager. So why did he feel this idea was wrong? I stated above that functional integration (of which a clinic manager is one element) would be difficult to achieve. Dr Lennox possibly thought likewise. Appointing a clinic manager would have meant addressing higher-level structural issues which cannot be done by just one clinic manager at one site. The problem would have to be addressed at the national level.

This meeting was the first time in the facilitated process that the power-play between the two managers was visible publicly. The power-play was not just about influencing staff but also influencing each other. I think that although the staff were in awe of Dr Cabral, Dr Lennox was not. What were the implications for the project of the power-play between these two key individuals? Section 3.2 introduced the concepts of public and hidden transcripts, and Scott's (1990) five strategies of dominance. These concepts – affirmation, concealment, euphemization, stigmatization and unanimity - can help explain the roles each group played during the facilitated process.

I find it difficult to judge how planned Dr Cabral's outburst was, but it certainly affirmed her champion status. The statement showed that she was willing to problem-solve and implement strategies that would facilitate successful integration, as she did for her tuberculosis intervention work. If she had planned the outburst, it was a good example of concealment with her anger about the time of the meeting, which does seem a little disproportionate since she arrived only 30 minutes early. In terms of Dr Lennox, if he was being obstructionist for the sake of power, he could have been seen to stigmatise by turning the conversation to others and challenging Yvette's choice of organising a workshop with all that eating. However, if he believed the process for change was wrong, he might have been concealing. Although he appeared obstructionist, he was concealing the fact that the clinic manager issue could not have been solved by himself and Dr Cabral. By agreeing to a clinic manager, Dr Cabral could have encountered larger problems than she could handle. If this interpretation is correct, he created the appearance of being obstructionist, but really he was dominating the process.

As I noted in section 3.2, dominance and resistance are complex concepts. Ortner's (1995) main critique is that a very binary view of power ignores other aspects of social life. When I started using these concepts, I expected that the managers would have been dominant towards the staff, and the staff would have resisted. However, the previous paragraphs have shown that although the managers were using dominant strategies, they were not used simply to dominate the staff. I can see Dr Cabral's background and gender might have been very important to her striving and thus her dominant behaviour. Barrett and Davidson (2006) discuss how women overachieve to transcend the obstacles of their ascribed gender roles. Not only would Dr Cabral have been trying to overcome ascribed gender roles, but also the issues of access to education and professions because of the gender and race context of South Africa. For Dr Lennox, I can see that he might have been taking a long-term view and perhaps even have been comfortable being seen as obstructionist for a greater good. Of course, I might be completely wrong in this interpretation, and he might have been obstructionist because he feared losing power. Later in this chapter, I discuss other events from this meeting which provide some insight on this issue.



In the end it is about what this means for the final success of the process as a whole. Dr Cabral made her statement about not wanting to chair and I wonder if she was signalling that she did not want to participate in the whole facilitated process. This interpretation is supported by the fact that she never attended another meeting at Paradise Park about the integration project. The next time I saw her was at the second joint planning meeting for the district on the 14th March, 2001 (discussed later in section 5.6), after the Paradise Park Project ended. Dr Lennox seems to have believed the integration project would fail from the start. I believe he did make an effort in the beginning with his support for the launch and the joint planning meeting. However, his commitment for the project was never complete, and he failed to attend any more meetings. I did not see him again in relation to the integration project.

5.4 Shifting authority

I think there are many things that people are not saying, like: “I see so many workers but you are just sitting all day”. (Dr Cabral)

Others work with less. (Dr Lennox talking about the number of general workers in other day hospitals and clinics)

As well as a shift in the commitment of key players, the 2nd March meeting represented a shift of authority. After the charged beginning with confusion over the start time and Dr Cabral’s outburst, the meeting continued in the same vein. Both Dr Cabral and Dr Lennox made threats about job security. Dr Cabral’s threat was veiled, focussing on communication and loyalty. At the start of the sentence above she seemed almost sympathetic and wishing for people to open up. The second part of the sentence was about telling on your fellow workers and implied that efficiency can be addressed in any which way needed (e.g. through job losses). Her comment came after two nurses highlighted that they needed help thinking about how to get started:

Dr Cabral: “What I see is that all are waiting. What it takes is that someone says: ‘I’ll go first.’ Why not do that now?”

Sr Hunt: (day-hospital nurse): “But how can we take over each other’s jobs? How can we swop? Who will do my job when I am not there?”

This made her threat feel more like the strategy of concealment: she first tried to cajole staff into getting on with the integration. Then, when a staff member wanted to know how she should organise this alongside her own workload, Dr Cabral made the threat. Dr Cabral controlled the public stage with the threat. She showed herself first as in control of the situation, and then when she realised control was lacking, she changed the conversation so that people felt threatened and they would forget the previous discussion.

Dr Lennox's threat, however, was relatively more direct. He even singled out a group of people: the general workers who were absent from the meeting. Dr Lennox's comment could be interpreted as him perceiving the absence of the general workers as defying his authority. He could be seen as stigmatising them by singling them out for this treatment. Undoubtedly, his words shocked staff, particularly since Yvette assured people from the beginning of the project that no jobs would be lost. His strategy can better be understood by identifying what prompted the threat:

Sr Hunt: "I want to ask something. Are the general workers/assistants integrated?
So when Deirdre is off, can Natasha do her work?"

Sr Theron: "No, we need them all."

Dr Lennox: "Others work with less."

Sr Hunt was a nurse from the day hospital and Sr Theron unofficially managed the clinic. More on their characters will be presented in section 6.2, but knowing them this would have caused a rift between the two services. Sr Hunt had a bone to pick with the general workers and Sr Theron would not take kindly to this. The conversation after Dr Lennox's threat is:

Sr Theron: "Yes, but this is a big building."

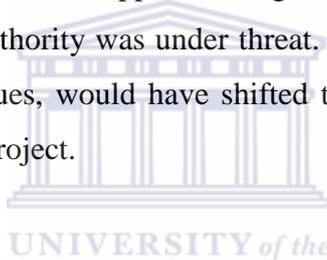
Dr Lennox: "Yes but ... there is one worker doing it all."

Sr Norman: "I think Sr Theron and I should discuss the general assistants together."

Sr Theron: "Yes, and they are not even here. That is not fair."

Here, Dr Lennox agreed with Sr Hunt, taking her side and making a job threat. However, his threat results in Sr Norman (who manages the day hospital) and Sr Theron banding together against him instead of Sr Hunt. It seems Sr Hunt's comment was all but forgotten as Dr Lennox was more powerful and thus frightening. To me this represents a concealment strategy again: Dr Lennox controlled the public stage for the greater good, although the strategy harms his reputation.

Initially, I worried about these job threats due to what happened one day early on in the process. Just after the launch lunch, Basil, one of the general workers, let it be known that he had called a trade union and he expected a representative to attend the next meeting. However, no representative appeared and Basil never mentioned the union again. Unions would play a strong role in protecting workers under contract in bureaucratic organisations in a democratic industrialised country like South Africa. As a reminder, the Paradise Park integration project focussed only on the integration of services, but not the overarching administrative and financial functions. Thus the integration process would have certainly raised human resource concerns among staff, including job roles and promotion. In this period of liminality, when normal processes are suspended, every aspect would have to be renegotiated. This would include issues such as pensions, promotion, and salaries. Strong involvement of the trade unions would be expected. As the unions failed to appear during the pilot to protect the staff, the legal/institutionalised-based authority was under threat. This aspect, combined with the following three contextual issues, would have shifted the basis or source of authority quite significantly during the project.



The first issue was introduced in section 3.4: historically in South Africa, nursing has been a profession strongly determined by gender and race. Access to jobs for women, and particularly Black and Coloured women, was limited during Apartheid. However, nursing remained accessible. This situation created a scarce resource in which job security is threatened by, for example, a change process. Not all nurses could leave their jobs in South Africa and join the brain-drain migration.

The second issue is within the change process itself. The pilot project temporarily suspended formal structures. Suddenly staff saw managers as holding the power to re-design the formal structures, despite assurances that this was a bottom-up process. Alongside the facilitator, managers now held the power to protect job security. This meant that personal relationships between managers and staff, without the equalising power of unions, could have become vital.

The third issue is that personal relationships already existed, although they were moderated by the formal structures of a bureaucratic DoH. Although the provincial authorities were more bureaucratic and formal, the municipal authority was intrinsically personable. Since the municipal authorities were going to be the leading authority at the end of this process, personal relations might have facilitated access to resources.

This situation could give way to authority based on dominance and patronage. Patronage has been identified as a way of working through giving rewards for loyalty among health personnel. Froestad²⁹ (2005a, 2005b) identified patronage among civic leaders in a black township in Hout Bay in Cape Town and among superiors and subordinates in Community Health Services organisations.

I wondered whether a patronage situation was emerging in Paradise Park, particularly when I heard about a phone incident that occurred on 2nd of March, just before the meeting in which the job threats were made:

11.00: Mrs Theron, Mandy, Ann, Linda (all from municipal authority) are sitting around the kitchen table when I come in. I join them at the table. Mrs Theron tells me Sr Norman (provincial authority) has ordered phones because too many calls are made from reception by the provincial side. Sr Norman told the men to install one in the waiting room and one in the tearoom while Mrs Theron was not there. She is angry. (My field notes, 2000)

This incident is analysed further from the perspective of staff in section 6.4. Here, I consider the perspective of management. The central question is why the area manager responded to this request for the phones, and responded so rapidly. Under normal circumstances something like this would be seen as quite a major change and expense. This discussion would be needed at the management level, staff would be consulted and the budget would be considered. Section 5.4 showed that the authority during the pilot

²⁹ Froestad was introduced in section 1.2 as a member of this project's health group, investigating trust in health institutions.

project shifted with a suspension of normal processes, as happened with this incident. Instead of institutionalised processes for decision-making, another process has occurred. Section 5.1 on authority hinted that personal relationships would become more important. In this case, Sr Norman, a relatively new member of staff, succeeded in getting phones installed by speaking to Mrs Lombaard, the provincial area manager. Although Sr Norman was new to Paradise Park, she knew Mrs Lombaard very well. After the meeting on 2nd March, I heard from various sources that Sr Norman used to work under Mrs Lombaard in the day hospital in the suburb of Retreat (situated in one of the southern suburbs in Cape Town) and still felt loyalty towards her. It seemed that this feeling was mutual if Mrs Lombaard could install phones so quickly.

Since this example highlights the issue of authority sourced in personal relationships, it would be useful to examine the concept of patronage used by Froestad (2005b) in his exploration of civic leadership. The patron/client framework was developed largely by anthropologists and it focused originally on informal exchange relationships in pre-industrialised countries. Scott (1990 p.96) created the following definition from seminal works on the patron-client framework:

The patron-client relationship – an exchange relationship between roles – might be defined as a special case of dyadic (two-person) ties involving a largely instrumental relationship in which an individual of higher socioeconomic status (patron) uses his own influence and resources to provide protection or benefits, or the client for his part, reciprocates by offering general support and assistance, including personal services to the patron.

Three key elements exist in a patron-client relationship: unequal and vertical, personal and informal, reciprocal.

The relationship is inherently hierarchical. Scott's definition states that the patron has a higher socio economic status. A patron can access resources that allow them to dominate the relationship. Examples of such resources are social capital, financial power or access to selective goods such as work, protection or market access (Scott,

1990, Gonzales-Acosta, 2007). The thesis has shown highly hierarchical relationships in health services; for example, in the command chain. Dr Davisson gave the command to integrate, and the managers and facilitator told the clinic and day hospital staff to integrate. In a more subtle manner, the hierarchy was evident in the seating arrangements during the launch lunch. The suspension of formal structures in the pilot project, the lack of moderating influence of unions and the scarce resource of nursing, as discussed above, created a foundation for authority through personal relationships or patronage.

From the client perspective, they enter into this relationship to access these resources and to insure against unforeseen changes in the environment which might affect, for example, changes in income (Platteau, 1995, Leonard et al., 2010). The client offers support and assistance to the patron (Scott, 1990, Platteau, 1995, Gonzales-Acosta, 2007, Leonard et al., 2010). The suspension of formal moderating structures meant that job security was controlled by those leading the pilot project (i.e. the managers). Access to resources gave the managers (the patron) power to command the client (the staff). This could explain some of the dominant behaviour displayed by Dr Lennox and Dr Cabral. They showed they have the power of a patron in their statements which threatened job security or shamed staff. With the legal and institutionalised processes suspended, the patrons would feel more certain that their behaviour would not be moderated by trade unions.

The patron-client relationship is informal, not structured by a formal contract or regulated by trade unions. The relationship is intrinsically personal: if the client needs something, he/she knows they can depend on the patron to respond positively (and vice versa). This creates affection and trust that are expressed in personal terms of address. Traditionally, terms of address are related to close kin (Scott, 1990, Platteau, 1995). Although the terms in the pilot project are not of close kin, the more personal relationship style among the municipal authority led to staff members addressing Dr Cabral by her first name.

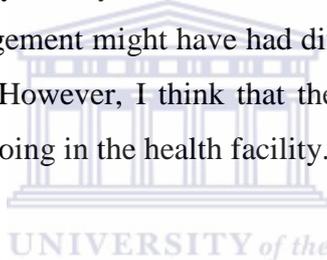
However, the patron-client relationship goes further than the reciprocal exchange of access to scarce resources for support and assistance. The relationship is strengthened through frequent symbolic exchanges and personal favours (Platteau, 1995). The favour of phones being installed by Mrs Lombaard for Sr Norman was an example. Other examples were given by Mrs Johnstone's statements that she will organise certain things:

I will get them for you. I'm busy organising it (referring to invitations to a joint planning meeting for the district and in service training, respectively) (2nd March meeting).

Initially, I was concerned that patronage was taking hold of the Paradise Park project. However, during analysis my view reversed. I think it was really about Dr Lennox diffusing the situation. Much of the argument for patronage and Dr Lennox as the obstructionist manager focused on the issue of job threats: threats against his own position and threats to staff jobs. But how real were these threats? The end result of integration would have been a district health system with the local authority holding more power. This change would have threatened Dr Lennox's position, given two managers would no longer be required. I am uncertain whether he could have found another job position at a similar (or higher) level.

The threat against staff jobs was somewhat different. First is the doctor from Paradise Park, who would have thought her job at Paradise Park was threatened, but at worst she would have been moved, not retrenched. Second are nursing staff, and I have explained that access to jobs for Coloured and Black women was limited during Apartheid. A main critique of this statement is the brain drain and the shortage of nursing staff in South Africa (Nelson, 2004). The plan of the integration pilot project intended to train nurses to become community nurse practitioners (CNPs). I think that had this training occurred, some older nurses would have retired. For nurses with less education, I imagine that nursing assistants would still be needed. It is more appropriate for nursing assistants rather than CNPs to do tasks such as preparing patients to see the CNPs and supporting treatments such as wound dressing.

Third are the general assistants, an important group to consider given the job threat by Dr Lennox was directed at them. Paradise Park had three general assistants: Natasha, Deirdre and Basil. Basil took care of the outside area which included the patients' toilets, a substantial garden, the entrances, etc. Fairly hard labour was involved, so I cannot imagine that he would have been retrenched and replaced by Deirdre or Natasha. Both women are middle-aged, and took care of the internal areas. So, it is perhaps more likely that one of them would have been retrenched. However, maintenance and cleaning of a health facility is more demanding than, for example, an office building. For instance, the standards of hygiene would be greater, and more importantly, both Deirdre and Natasha had additional tasks. These tasks include preparing food daily, preparing baby-food baskets for poor people, regular stocktaking, assisting at the reception area in the morning, frequently preparing coffee and tea for the breaks of different staff groups, etc. In my three years at Paradise Park, I rarely saw either of them sitting down. Of course, management might have had different views on the importance of the two general assistants. However, I think that the general assistants' tasks were important and always needed doing in the health facility.



A final issue is that, despite that the staff were being asked to make changes for the integration pilot project, their job descriptions were unchanged. Moreover, every staff member in the Paradise Park facility was doing their usual job role every single day, pilot project or no pilot project. It seems inappropriate to me that staff could be fired for doing their jobs well (as described in their job descriptions) unless the job descriptions are revised to reflect the tasks demanded from integration.

In summary, initially I thought that patronage was emerging because formal structures were being suspended, and the case of the favour of the phones being installed. However, the day-to-day running of the health services in Paradise Park continued much the same and the administrative structures were unchanged. Job descriptions remained much as they were, as did promotion and pay. If patronage was really taking hold, more cases of suspension or replacement of formal structures would have been evident.

5.5 Commitment

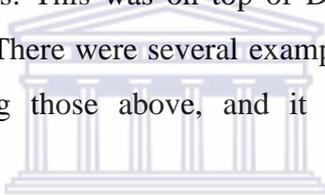
Sr Norman (provincial authority): “There is no work plan, no practical way to go.”

Dr Cabral: “Working plan’s come to nothing. We should do one things at a time with Yvette’s list and the steps forward.”

Sr Theron (municipal nurse): “There is a shortage of admin staff on our side.”

Dr Cabral: “We should use Yvette’s list to evaluate.”

In section 5.4, I hinted at the issue of commitment when discussing Dr Cabral’s and Mrs Johnstone’s threats. This meeting was peppered with questions from staff, with Dr Cabral and Mrs Johnstone stepping back from these questions one way or another and not committing to any answers. This was on top of Dr Cabral’s statement about not wanting to chair the meeting. There were several examples of this lack of commitment during this meeting including those above, and it is finally epitomised by Mrs Johnstone’s final statement:



Solve one problem at a time. If you have any problems, call us in.

WESTERN CAPE

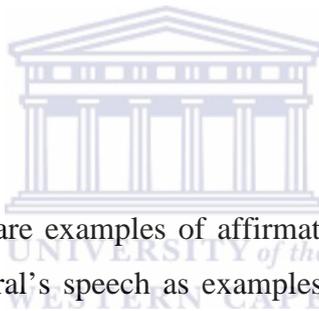
I do not think this not committing to any answers as a whole is categorised as a strategy of dominance, although it is a way of controlling the public stage and keeping up appearances. The managers’ responses of not working towards or providing solutions suggest another factor. I think Dr Cabral’s lack of commitment and referring the task related to integration to someone else (Yvette and the staff) showed that she did not believe this project would be successful. I have already established that Dr Lennox took this stance from the start. Although both managers showed their unanimous support during the launch, this meeting on 2nd of March is the first meeting where practical issues needed to be solved. Both might have viewed the project differently before the start, but this meeting is where it played out in full view for the staff. Not only are the struggles behind the scenes evident at the meeting (e.g. on whether a clinic manager needs appointing) but their lack of commitment to find real solutions was also emerging. This, I believe, signalled to the staff that they cannot count on their managers

to help them with the implementation of the project. This is also the last pilot meeting Dr Lennox and Dr Cabral attended. Similarly, Dr Davisson failed to attend despite previously confirming his attendance. This meeting seemed pivotal to the success of the pilot project and the managers' failure to deliver.

As will be discussed in the next chapter, the facilitated process ended on 1st March, 2001. The area managers are the only managers who attended this meeting. Neither Dr Lennox nor Dr Cabral attended any more meetings.

To conclude the discussion of the role of the managers in the integration project, one more event needs discussing: the joint planning meeting on 14th March.

5.6 Joint planning



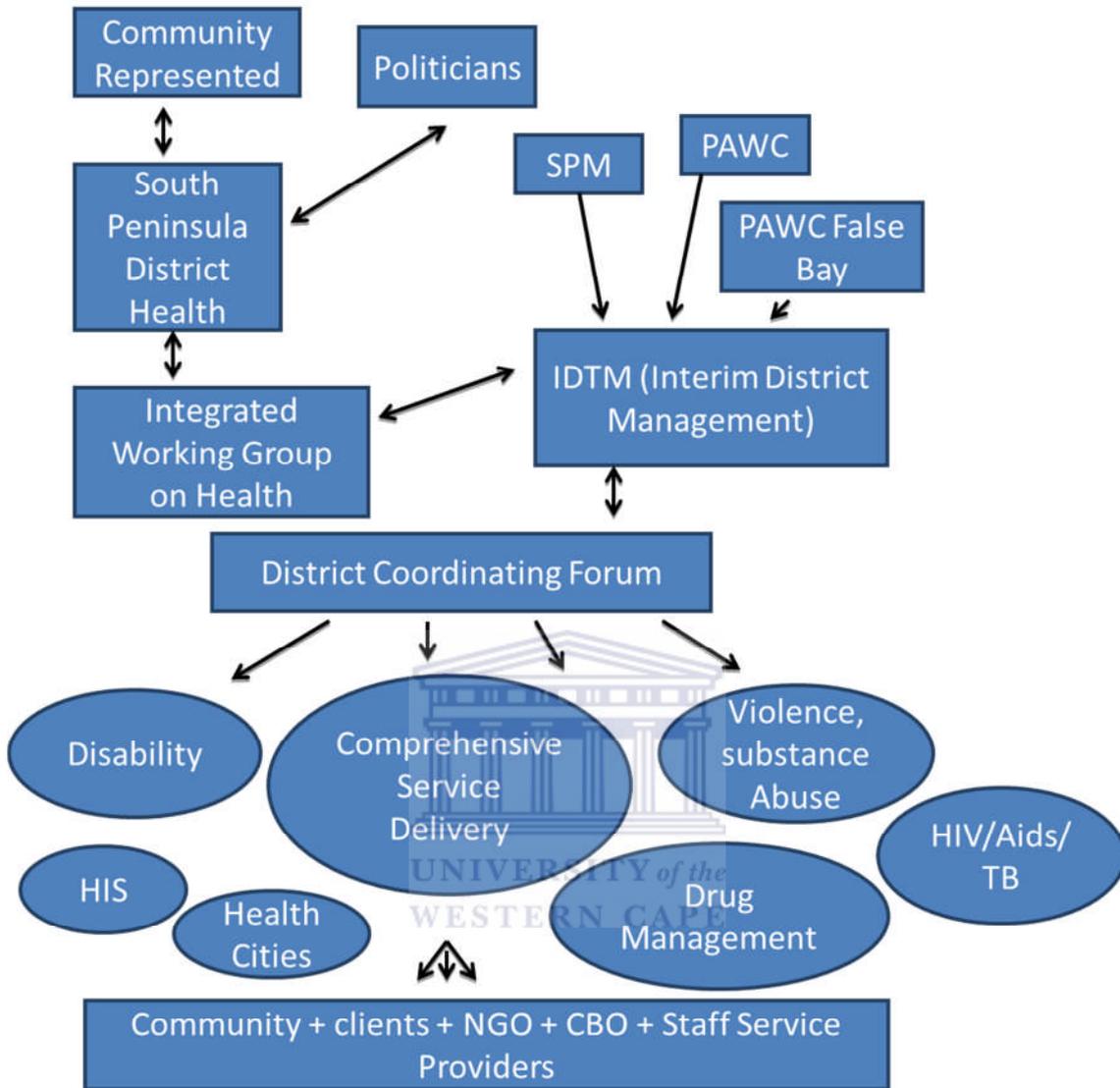
Both joint planning meetings are examples of affirmation and I used the second joint planning meeting and Dr Cabral's speech as examples of her position as a champion (see section 5.2). Both are still the case but the timing of her speech after the end of the integration could throw a different light on her motivation. By citing her impressive tuberculosis cure rate, she showed to staff that she is still a good leader, despite the failure of the Paradise Park project. She presented her cure rates as unrivalled globally. It was an interesting statement to make, given that a 100% cure rate was impossible. Mrs Theron, who specialised in tuberculosis, informed me that adherence is a problem in Paradise Park and Numzamo. Therefore a 100% cure rate, even for just two clinics, was not possible. I am sure she was not really lying, but statistics can be collected and presented differently. I am unsure how many audience members would have believed the 100% statistic. However, my experiences on fieldwork suggested that nurses and doctors found statistics very convincing. Statistics definitely serve to "magnify the awe in which managers are held", as I defined in the strategy of dominance.

Considering the timing of the joint planning meeting I am also seeing other elements of it in a slightly different light as I will discuss below.

The managers reported on the progress of the integration with the organogram shown in Figure 3 below. The ended project of Paradise Park was unmentioned. The organogram shows how a functional structure was created for the facilitated process. It was also a clear example of unanimity both in the central position of the Interim District management team, the representation of all actors and the links between them. Note also the appearance of unanimity in the task groups (those presented under the District Coordinating Forum in the organogram). It suggests that all staff members were cooperating to improve health in the district. The task groups and their position in the organogram also gave the impression that the managers were working very hard to get this process of integration and the creation of a district health system on its way, with no failure of projects or obstruction of the process by management.

In summary, the joint planning meetings were clear displays of power i.e. showing how well management were doing in all the districts, and how their leadership produced positive change. These displays are examples of affirmation by showing how well management (particularly Dr Cabral) are doing, concealment by strong control of the public stage and unanimity between management and among staff members.

Figure 3 - Organogram of functional structure of the District Health System



5.7 Conclusion

The discussion of the role of managers in the facilitated process has shown clearly that Yvette's original fears (see section 4.5) were indeed well founded. However, her fears did not come from the origins she imagined. Dr Cabral was not so much enthusiastic but ambitious. She addressed the process with a business-like attitude which she expected would result in success. There is no benign part to this approach as she came from a background where she had to fight for recognition as a Non-White and a woman. From the meeting on 2nd March 2000, it becomes clear that she had ideas on how to progress the facilitated process with the appointment of a clinic manager. She was blocked by Dr Lennox who was not acting for the sake of being obstructionist but because he understood the realities of the change process. Integration was a larger problem than could be solved at the clinic/day-hospital level.

My analysis of both managers' actions has shown how the concepts of dominance and resistance can be strengthened from a binary view of power to incorporating the many factors (such as race and gender) which influence choices of strategies. In the next chapter, the responses and roles of staff are analysed, using resistance as a concept.

Chapter 6 - The facilitated process of integration: staff and the community

Chapter 4 on planning outlined a carefully orchestrated plan and positive start to the facilitated process. It showed that the aim of the process was to focus solely on the functional integration of service tasks and create a “multi-purpose clinic with multi-purpose staff” in line with the view integration developed by WHO (1996). Although affected by the process, financial, administrative and human resource systems (including salary or promotion structures) above the level of the clinic and day hospital remained unchanged. Chapter 4 also highlighted the expected participatory role of staff members and strong guidance on which steps would be taken to achieve integration. In Chapter 3 the history of nursing and the expected pressures on nursing practice from integration were described, highlighting that unless these issues were accounted for, integration would be difficult. This current chapter will describe the process of facilitated integration from the perspective of the staff members, to complement Chapter 5’s perspective of the managers. I examine the process events chronologically, using the useful concept of resistance to analyse staff responses.

6.1 Staff at Paradise Park

At our first meeting, Yvette told me nothing about any staff members. I got to know each of them gradually during the facilitated process. Table 3 summarises the staff members, the service they belong to and their related tasks. The table rows are ordered hierarchically, matching the structure present (see section 4.8 on the launch lunch). The staff members are listed by the terms of address used by other staff members, as this indicates their status in the hierarchy:

Table 3 - Summary of staff members

Job function	Clinic	Main tasks	Day hospital	Main tasks
Doctor			Dr Uys	GP
Pharmacist			Eva Foster	Dispensing
Nurses in charge	Mrs (Stacy) Theron	Tuberculosis	Sr Celia Norman	Administrative
Nurses	Dorothy (Trytsman)	Family planning	Pauline Hunt	Prepare patients for the doctor, follow up activities including blood samples, course of injections
	Mandy (Stuart)	Paediatrics		
Nursing assistant	Varied: Linda, Suzanne	Prepare children for nurses, reception, admin and medical supplies	Veronica (Maartens)	Any tasks with wound care as a self-pronounced speciality
Reception			Mrs Theunissen	General reception and coordination
			Tony	Filing, phones
General assistants	Basil	Cleaning outdoors	Deirdre	Cleaning indoors
	Natasha	Cleaning indoors, food parcels		

6.2 Expected outcomes from integration

Integration would mean a better service because it would be a one-stop service, where mom, baby and everyone can come on the same day. It's when they come on separate days that you lose your clients. At present someone with an ailment can be referred for two months, but if you have a problem it needs to be seen to now (Stacy Theron, clinic manager).

It won't make any difference, we all have our duties...they can swap us around as much as they like but it will be back to square one. If we take someone from

tuberculosis to do dressings we are just left with no one to fill the tuberculosis duty. If they think they can improve things without bringing in more money and more staff, they are fantasising (Pauline Hunt, day-hospital nurse). (SAHA, 1999)

Above are two quotes from nurses at Paradise Park, who in 1999 were the most senior nurses in their respective services. Both quotes were given to an interviewer from SAHA, a colleague of Yvette, in response to a question on what they believed the integration would achieve.

The clinic manager

The first quote shows a fairly positive view from Stacy Theron, the clinic manager, employed by the municipal authorities. She was a Coloured woman and (if I recall correctly) born in Lavender Hill, a Coloured area in the Southern Suburbs, located along the main road from Cape Town to Fish Hoek. This township had better access to public transport than many others. During my time at Paradise Park, it sometimes felt as though she was in charge of the entire service, including the day hospital. She was referred to often as Mrs Theron instead of Sr Theron, a greater term of respect. Mrs Theron had a strong personality. She had worked at Paradise Park for 25 years and knew almost everyone in the community. On paper she was only acting in charge, although all staff and community members viewed her as the clinic manager. I am not certain why this occurred. It might have been that the municipal services did not have a nurse in charge. I also do not know what she thought of her acting (rather than official) role. Since she always acted in charge and had the capacity to influence people, perhaps it was unimportant. She had been with the clinic since the beginning and that gave her position strength and authority. In my observation, she had the authority to make important decisions at the clinic, and all staff members respected her view. She is a good example of achieved status i.e. in the many years she worked at Paradise Park, she earned her position with her colleagues, the patients and the community.

In terms of work, Mrs Theron's specialisation was tuberculosis but she also saw children under five and provided family planning services. I observed that she walked

around a lot during opening hours and chatted to people in the waiting areas. As the quote above shows, Mrs Theron often said that she was there to serve the community and that the community is most important. I realised the truth of this statement when she took me to see the Mountain View community at the start of the integration process. Mountain View was situated on the outskirts of Paradise Park, and was reached by leaving Paradise Park on the main road towards Kommetjie and turning up a dirt road a few minutes later. Mountain View was built as a temporary settlement 20 years ago. However, it remained permanent. This result is an area with concrete, barrack-type small houses lacking floors or ceilings. This caused rain to fall straight into the house through the gap between the roof and the wall. I spoke to a woman who explained the consequences on health:

Kiners [children] sleep on the ground and they get sick. (I14)

Toilets and bathrooms were separate from the houses. These sanitary facilities were dirty and often the water stopped running and people were unable to wash or flush. Overcrowding existed, with several families sharing a small house. Money was lacking to improve the facilities, which affected health:

The inadequate plumbing brings sickness mostly everywhere. This is mostly everywhere. Before, fixing was free from the government. Now they charge for it.

They have a broken toilet and have to pay to fix it but they have no money. (I63)

Living conditions might not have been ideal elsewhere in Paradise Park, but Mountain View was the worst. Interestingly, the media did not recognise Mountain View as a separate area to Paradise Park, but the differences were stark.

Just before we turned off into the dirt road in Mrs Theron's car, she gave me some instructions. She told me that when we got out of the car I should leave the window open, leave my things on my seat and leave the door ajar. She said this would show the people of Mountain View that we trusted them. People from Mountain View suffered from much stigma. The lack of plumbing made it easy to identify Mountain View

people from any other people in Paradise Park because of their body odour. Combined with their abject poverty, Mountain View residents were perceived to be more likely to steal. Mrs Theron carried a bag with medical supplies. It was clear to me that she knew everyone. She would greet the people we met with their name and enquire about a family member: “Had his sister had her baby?” or “Was her father still working away?” Although we were due to visit only one patient, she listened to anyone who asked her medical questions. Due to my background her approach really endeared her to me and made me more favourable to the clinic staff. Why did she take me to Mountain View? I believe she wanted me to appreciate two things: first, community differences due to poverty and second, she wanted me to see her achieved status right from the start of the facilitated process. She never offered again to take me to Mountain View and I do not know if she went again during my fieldwork.

Returning to Mrs Theron’s quote, she presents a vision of a one-stop service. I heard her use the phrases one-stop shop and supermarket model during my time at Paradise Park. As Yanow (2000) considered when talking about symbolic language (in particular, metaphors), Mrs Theron’s phrases need to be related to the meanings of these retail terms at that time and place. In Cape Town in 1999, the bigger supermarket chains were expanding and offering more goods besides food. I remember the Pick and Pay supermarket I used to visit vastly expanded its range to include clothing, household items, health foods, and imported (mainly European) foods. Other supermarkets introduced pharmacies and employed nursing staff to provide medical advice and drug prescriptions. The supermarkets were large, open-plan, with bright lights, air-conditioning, and well organised with clear signposting of aisles. These one-stop shops stopped the need to go elsewhere: all needs were met at one shop.

This retail experience was vastly different from that in a local corner shop, found in most suburbs including Paradise Park. Corner shops usually were not well stocked, not well organised, and food was of lower quality³⁰. However, corner shops had the

³⁰ Particularly due to the combination of hot weather and lack of air-conditioning.

advantages of being in walking distance, convenient when you run out of an item and being run by a friendly neighbour. However, this last quality caused problems for private or confidential purchases. I saw young women use a corner-shop to buy cigarettes while looking around to see that no-one saw them, and urging the shopkeeper not to tell anyone.

So, what are the implications of this retail context for understanding Mrs Theron's quote? Her vision was of a service very much like these supermarkets: one-stop would give a patient everything they need. A wide range of services would be available, well organised and easy to access in a large building. This interpretation is confirmed by what she said next:

Yet still, [we] need more staff and a larger facility long before they can even think of integration, because that is what it would take to make it work.

The day-hospital nurse

The second quote at the start of this section is from Pauline Hunt and has a comparatively more negative feel. She was the main nurse at the day hospital, and the only nurse from a White English background in the building. To me, her work ethic was the very opposite to that of Mrs Theron. Pauline Hunt arrived at the building and stayed in the day hospital except for breaks, calling patients individually and processing them for the doctor. She did not know their personal histories nor did she walk around chatting to people. She was referred to as Sr Hunt by most people, reflecting her status as a nurse in curative services³¹. During my fieldwork I thought often that the only reason she worked in Paradise Park was because she and her family lived just up the road. Working at any other clinic would have required her to travel for half an hour or more. This interpretation is supported by a statement she made at a meeting in June, 2000. On being asked about the advantages of Paradise Park, she replied, "It is not far from my house". Her job was to prepare patients for the doctor and take blood samples, blood pressure and weight if ordered by the doctor. One of Pauline's pet-hates was the

³¹ Most clinic nurses (except for Mrs Theron) were referred to by their first name.

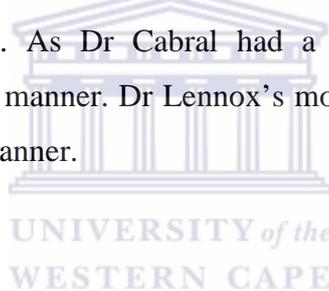
general assistants. She told me: “They always sit there [the tearoom] drinking tea and chatting away while the day hospital is filthy.” This seemed a long-term irritation. I found out that Natasha, from the municipal services, often refused to take orders from Sr Hunt. I recorded in my fieldwork diary one incident when Pauline clashed with Deirdre:

Pauline and I are alone in the day hospital and are having a chat about one of the meetings on the integration that took place the week before. Pauline wondered why there are two cleaners. She then says: “And who has cleaned in here? No one. There is dust everywhere.” She checks for dust with her index finger. She looks on top of the scale and on top of the notice board. She tries to lure me into saying that one cleaner is enough. She adds: “They are just talking all day. Don’t you think one is enough?” Pauline then proceeds by fetching the cleaner and pointing out the dust. The cleaner growls and dusts in anger. After the cleaner left, Pauline says she does not like doing this. Her body language says different: she looks more like a lieutenant with her hands on her hips and her condescending tone. She seemed to be enjoying it. (Fieldwork diary, 26th January, 2000)

As well as an example of Sr Hunt’s dislikes, the outburst was quite likely a response to the facilitated process and my presence. This will be explored further below.

Considering that she grew up in South Africa and during Apartheid, she might still have viewed Coloured people as irresponsible and possibly dirty. As section 3.3 showed, she would quite likely feel that Coloured people have to be reminded of their job. It also occurred to me that Pauline might have found it difficult to be among so few White people considering that nursing was not only a gendered profession but also one of the few professions available to Coloured and Black women (see section 3.4). I wondered also why she had questioned me on the cleaners. It occurred to me that this was a similar incident to the one with the pharmacist (see section 4.9): as I was White, I might have been sympathetic to her views. Alternatively, she might have been trying to get the cleaners into trouble with me as the facilitator of this process. Perhaps both explanations are valid.

Comparing Pauline Field's and Mrs Theron's statements, do they have similar views of the likely outcome of the integration project? Although Pauline Field's statement reads more negative in the first instance, I think both statements are in accordance. Both statements suggest that without more staff and space, the integration project is likely to fail. What is most telling is that Pauline Field's chose to cite tuberculosis. Using narrative analysis, it is important to remember the statement is made by a day-hospital nurse. She referred to a task which is part of a vertical health programme done by the clinic nurses. She did not say that tuberculosis services would have to be provided by all staff. Also, she did not use one of her own tasks as an example. Perhaps she felt she already was a multi-purpose type of staff member. She could also have believed that curative tuberculosis work is real nursing as opposed to clinic work which is mostly preventive. It also occurred to me that nurses are influenced by how their respective managers express themselves. As Dr Cabral had a positive attitude, Mrs Theron expressed herself in a positive manner. Dr Lennox's more negative attitude might have influenced Sr Hunt's similar manner.



Multi-purpose staff

Section 3.4 described how the integrated health system ultimately would have CNPs running the health centres, with doctors moving to the hospitals. This change suggests that all nurses would treat any patient and nurse specialisation would end. The two quotes at the start of this section suggest Mrs Theron realised this change would occur, but it is unclear if Sr Hunt thought similar. Issues relating to transforming nursing practice were discussed in section 3.4 including a shift to preventive services, workload and devaluation of nursing. I now examine these themes, in relation to the context of Paradise Park.

By emphasising preventive services, integration would have refocused the work of the clinic. This reflects why the municipal authority was being favoured to take the lead within the district. Nurses would have played important roles in the envisioned PHC element of community's responsibility for their own health care.

6.3 The workshops

Chapter 4 on planning showed the positive and carefully orchestrated start of the facilitated process. The above discussion of Mrs Theron's and Sr Hunt's view of the outcome shows an undertone of insecurity and fear of failure. Both parties identified that more staff and space were needed for success. The discussion also identified that unknown legal implications might have emerged for multi-functional staff. Combining these challenges with the challenges of functional integration (see sections 4.4 and 5.3), indicated that Yvette would struggle to make the integration process work.

With these challenges in the background, Yvette started the facilitated integration at Paradise Park. This careful orchestration of the facilitated process continued with the workshops. This approach reflects the facilitated process being dealt with as a rite of passage. As discussed in section 4.3, the facilitator/magician coaxed the staff members into a transitional state. This coaxing continued with the workshops, which diagnose initial feelings, fears and problems (first workshop) and the health centre's strengths (second workshop).

The first workshop was held at the Little Stream conference venue in November, 1999. As the name suggests, the venue (a former private house) was close to a stream with a large lawn and sprawling woods. Little Stream was located in the heart of the rich neighbourhood of Constantia. This location was the exact opposite of a poor township such as Paradise Park. The workshop venue can be seen as a symbolic separation of staff members from their daily workplace, bringing them into a spiritual state reinforced by the tranquillity of the venue. This location continues the rite of passage guided by the facilitator/magician.

Worries and suggestions: workshop 1

Why can't we stay as we are? We can just jump in when we are needed.

The worries voiced at the first workshop were similar to those brought up by Sr Theron and Sr Hunt (see section 6.2). The discussion of functional integration in section 4.4 identified that salaries and promotions would not change. The following quotes from the workshop highlight these concerns:

What is the official date for integrating the salaries?

What will happen to the conditions of service in the two departments?

Mrs Theron and Sr Hunt both highlighted the need for more staff, views similarly voiced at the workshop:

Will the staff complement be increased? Or do we have to work with the same amount of staff?

We'll need more permanent staff to keep it working.

Three other main worries emerged. The first is whether staff could choose whether or not to integrate:

Will we be forced to integrate if we are unhappy?

Can we say no?

The second worry was how the integration would happen, with focus on leadership and training in particular:

Who will be in charge? PAWC [provincial authorities] or SPM [local authorities]?

Will we receive in-service training?

The third worry was about the community's role in this process:

Who will ask the community about what they want and how they feel?

The first worry reflects the insecurities that a facilitated process inevitably brings, whereas the second worry is related more to the practical issues of integration. The third worry relates to the planned internal focus of the process and the aim of serving the community rather than including the community within the process.

Would these worries undermine the process of integration? The worries were voiced with the facilitator/magician guiding the first stage of the change process as rite of passage. The workshop allowed the problems to be diagnosed and fulfilled the promise of consultation. Staff members were reassured by being given a voice and the idea that they could stop and/or decide the pace of the process. The workshops fostered the belief in the cure which was promised at the launch lunch, and reinforced the perception that the facilitator/magician had the right skills to lead this process.

My role as a facilitator

It has been a wonderful day. This day was only the beginning.



The first workshop was facilitated by myself, and I take on a strong facilitator/magician role (see section 4.3 on the roles of facilitators). On arrival, staff members were given hot drinks and doughnuts. Two warm-up exercises followed:

- a) Name labels to wear, stating a person's name and a positive adjective.
- b) Staff then introduced themselves to one other person, focusing on something that they did not know about each other.

These exercises were designed to bring a personal touch to the start of the workshop. I hoped that staff would be kinder towards each other, with less arguments or blame. The next activity was an exercise in which staff members could express their worries. After lunch I ran an exercise to encourage thoughts on successful experiences, followed by an exercise to construct a way forward. The exercises resembled a rite of passage: I first coaxed staff into a separation state with the warm-up, getting them ready for change.

Then, time was available for voicing worries in the uncertain, transition stage. Finally, incorporation occurred by looking forward towards solutions.

After the workshop, I produced a consolidation document workshop filled with positive reinforcement (as the quote above shows). The document began with a picture of an oak tree, symbolising strength, courage and togetherness. The quote and the picture indicated to staff that more positive events would occur: more change and a promise that it would be good and positive (i.e. well facilitated by skilled facilitators/magicians). My consolidation and role in the first workshop made me a facilitator/magician by controlling the manner in which information was given to the staff members in the facilitated process.

However, I should acknowledge a limitation in the description above. At the first workshop I did not know the staff members well. Also, my busy role as a facilitator meant I was unable to make detailed notes on who said what. I did use the notes from Yvette from this day who would of course see this in a different light as the main facilitator, and I reflected upon the experience in my fieldwork diary. This hampers further analysis of the quotes and thoughts from the workshop to some degree.

Strengths of Paradise Park: workshop 2

We are learning for the whole country. (Yvette)

Focusing on the centre and its strengths, the second workshop occurred six months later. This date was two months after the pivotal meeting described in section 5.3. At the start of the workshop, Yvette gave the staff time to voice their grievances about the process so far. Then, similar to the first workshop, we focus positively on the strengths of the facility, the reasons why people come to work and a forward-looking view on how problems could be addressed. This similar format allowed staff to be heard and yet leave with a positive forward-looking view.

Both workshops were meant to diffuse tension, manage the anxiety and pain caused by introducing the facilitated process, and work on juxtaposing the old versus new job roles. As discussed further in section 6.4, staff would have felt particularly ambiguous after the pivotal meeting on 2nd March.

The workshops served to guide staff through the period of ambiguity with ritual actions. Staff members were brought outside of their daily work situation and into a different state of mind (spiritual state) to discuss change (the rite). Magic language surrounded these meetings. The quote at the start of this section is one example. Other examples, identified here and in earlier chapters, included staff consultation, the centre and its strengths, the learning district, and community participation.

Some of the language used in the facilitated process (such as decentralisation, integration, inequality, and scarce resources) originated from the international arena and government organisations. These words served to support the impression of the skilled, knowledgeable facilitator. Other words were chosen by Yvette and reproduced by myself and management in conversations and project documents.

The second workshop was an example of the effects of the facilitated process. However, the second workshop is a culmination of events before this date. Before discussing the second workshop it is necessary to take a step back.

6.4 Resistance

One critique from my analysis of the planning stage was the strong focus on those with power in the discussion of the facilitator as the magician and the use of controlled space. Both arguments leave little room for agency and acts of resistance. Nor do these arguments account for other contextual factors such as gender and race (discussed in

Chapter 3). The following section focuses on the responses from staff and will clarify the complex acts of resistance.

I quoted Foucault in Chapter 3: “where there is power, there is resistance” (Foucault, 1979 p.95). I emphasised that these acts of resistance can be found, in line with Foucault’s thinking, particularly at their ultimate destinations: in the project meetings. Chapter 5 on managers showed the acts of dominance and power and (as Foucault predicts) acts of resistance. These were expected as similar acts were reported in the previous pilot projects (Owens, 1999a). This report, and others like it, omits how this resistance translates to actual responses. Resistance is not, generally, exhibited publically, as will become clear below. Previous chapters have shown how resistance was reactive: staff members responded to the facilitated process and the change of power relations in the integration process. However, resistance was not reactive in terms of open revolt, or rebellions which showed clearly the agenda of the resistance. Instead, resistance was more subtle as the determinants might not have been publicised. Open rebellion would have been too dangerous as it could have led to loss of jobs and problems getting a new job in the same sector. Instead, resistance was enacted daily using many strategies. By analysing the way in which the hidden transcript and other strategies of resistance were present in the public arena, we can uncover the real voices of the staff members. As participant observation was part of the methodology, I am able to give some insight on the hidden transcript that was spoken outside the public arena (i.e. outside the gaze of management). As a reminder, Table 2 identified Scott’s (1990) (1985) four strategies of resistance: flattering, hidden transcript, disguise/anonymity, and rupture.

I considered two ways to structure this section: by strategy or by staff member. I felt that a structure based on strategies would make them too central to the story. This could result in the people themselves melting too much into the background. A structure by staff member would make staff members central, but then the facilitated process might similarly disappear into the background. Finally, I chose the major issues that stood out to me during the facilitated process. This approach shows what, to me, were the main

problems that were caused by the facilitated process, the responses from those involved and a description of their backgrounds. I will highlight three issues: ownership of the building, scope and training needs. All three issues show the differences between the two services, which despite the aim of integrating both into a single facility, became more pronounced during the facilitated process.

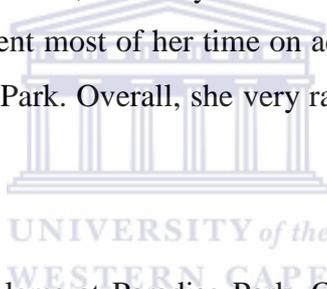
Two services

This is our building and we have nothing to say about it. (Mrs Theron)

On the 2nd March 2000, I arrived at Paradise Park and found the clinic staff seated around the kitchen table. Mrs Theron told me that Sr Norman has ordered new payphones to be installed in the building. This story was told from the managers' perspective in section 5.3; here, it will be recounted from the staff's perspective. According to Mrs Theron, the phones have been changed because she felt too many calls were being made from reception by the day-hospital staff. Sr Norman ordered the workmen who arrived that morning to install one phone in the waiting room and one phone in the tearoom. As the quote shows, the clinic staff were very angry because they were not consulted about this change to their facility.

The incident brought the issue of ownership of the building to the forefront and showed the separateness of the two services. As well as showing the tension between the two services due to the facilitated process, it was also a good example of a hidden transcript. The debate around who owns the building and who decides what happens in the building is an example of self-assertion outside the gaze of management. The clinic staff, particularly Mrs Theron and Dorothy Trytsman, often stated that the building is theirs (i.e. the municipal authority's), and they should decide what happens in the building. As one of the longest serving members of staff and acting in charge for the clinic, Mrs Theron used the issue of ownership of the building to add power to her position. However, the staff cannot make these decisions so they expressed their anger with these statements, outside the gaze of management.

The person who organised the change to the phones was Sr Celia Norman, the nurse in charge at the day hospital. She moved to the Western Cape from Gauteng Province to take up a more senior position. Her ambition might well have been linked to her being Coloured. Access to higher jobs would have been difficult during Apartheid (as discussed in Chapter 3), and she might have felt a drive that is linked to the new opportunities open to her in the new democracy. Of course her ambition might also be related to her social class instead. She might come from a family where ambition is not only highly prized or expected but where financial support makes it possible for her to pursue her career. She worked at another day hospital in the greater Cape Town area for a year under Mrs Lombaard, before moving to the Paradise Park day hospital in 2000. Their strong bond was evident in the incident over the phones. Sr Norman phoned Mrs Lombaard asking for the payphones, and they were installed within about a week. At the day hospital Sr Norman spent most of her time on administrative tasks in her office and meetings outside Paradise Park. Overall, she very rarely spent time with patients in the treatment room.



I have seen her report on problems at Paradise Park. Other staff members do not talk about these problems or pretend problems are solved. She emphasised often that the day hospital is so small that dry and wet wounds had to be dressed in the same area. Also, she was appalled that the day hospital's treatment room served also as a mortuary. Use of the room for treatment of patients was restricted for quite a long time, as a body was stored until the family could collect it³².

I do not believe her behaviour had much to do with the facilitated process although the response by the clinic staff was related to the process. Sr Norman's behaviour made her appear as an ambitious woman. Being new in this position, she might have wanted to show management that she was the right person for the job by identifying ways to improve practice. Changing the payphones would save money by reducing the number

³² This situation occurred twice during fieldwork.

of private phone calls. She would have hoped that improvements like this would bring her to the attention of managers and aid her career progression. She was quite likely correct, as she was one of only two people at Paradise Park services to be chosen for the CNP role (see more on this below).

The payphone incident was an example of the differences and the tension between the two services. I believe Yvette realised these tensions existed and took action. At the second workshop on strengths, three months after this incident, Yvette announced:

I'm actually going to call Paradise Park clinic and day hospital Paradise Park Health Centre so that both centres are included.

Yvette knew about the issue of ownership and she was aware of the phone incident. As a facilitator/magician, she tried to unify the two services and used a magic word to accomplish this. Labelling the two services under one name also suggested integration would have been accomplished. After this announcement, I saw the shock on the faces of (particularly the clinic) staff. By being joined in name, did staff from the two services still have a say over their own building? The announcement showed the power of magic words. However Yvette's announcement, clearly framed as her own decision, conflicted with her promise of staff consultation.

Scope

Alles is nie my scope nie!. The things I want to do I cannot do. Anyone can give me work. As long as it is my scope. (Veronica)

The issue of scope has two elements: first, what a staff member is allowed to do given their job role and qualifications, and second, who they do their job for. Veronica's quote, from the workshop on the 1st June, 2000, refers to both elements. There were tasks she was asked to and wanted to do, but she might be prevented from doing them as a nurse auxiliary or because she would work for the clinic. The issue of scope in the

integration process made several staff pawns in the power play between the two services. I will show how their low ranks and lack of skill made them easy targets.

Veronica Maartens was a nursing assistant and originally from Paradise Park. She was a nurse auxiliary who learned on the job. She made a distinction between herself and book nurses, and felt she was much more suited for the job as she learned through doing. In light of sections 3.3 and 3.5, Veronica's inability to access book education is unsurprising. Paradise Park's isolation would have made it difficult for her to travel to higher education facilities, which I think, from her age, would have been around 30 years ago. Veronica was always called by her first name which denoted her relatively low status in the day-hospital. I observed on numerous occasions that she was well loved. For example, patients preferred her for wound dressing and injections, saying she had a gentle hand. However, nurse auxiliaries should not provide injections, particularly not without supervision. This tension caused a dispute between the day hospital and clinic staff and prompted her quote above. Sr Theron had diagnosed a patient with a condition that required a course of injections. She assigned the patient to Veronica for these daily injections. When Sr Hunt found out she was very angry and said that she could not commit to these daily injections as she had not been consulted and she had to supervise Veronica.

Tony is another staff member who was affected by this issue of scope. Tony worked on reception at the day hospital as an administration assistant. Like Veronica, being called by his first name denoted his low status. His access to education would have been similar to Veronica although he is much younger (early 30s). In February, 2000, he was asked to take an elderly patient home as a favour for one of the clinic staff. The old woman had trouble walking and needed help. When he returned, he was told he would be reported if he did it again.

I think these are good examples of the hidden transcript: the other members of staff expressed their discord and anger with the integration process by picking on the less powerful. It is clear that the hidden transcript is not simply one side of a binary

representation of power. Hierarchy plays a role, I believe. Both Veronica and Tony could have been reported by those in charge of the day hospital to the area managers for working outside their scope. Such a complaint could have placed the lower-ranked staff members' jobs in jeopardy. The higher-ranked staff played out their anger on lower-ranked staff rather than doing so with staff of equal rank or directly with the other service.

The treatment of the general workers discussed in section 5.4 was another example of the scope issue. Their example potentially had more serious implications as the issue was brought before managers (i.e. the rupture strategy of resistance) and the general workers' jobs were threatened. However, I argued in section 5.4 that particularly Dr Lennox's comment was meant to unite staff rather than to threaten. Of course, the threats might have been interpreted differently (and more seriously) by the receiving parties.

The clinic has two general assistants (Basil and Natasha) whereas the day hospital had one (Deirdre). All three were born and lived in Paradise Park, and would have experienced similar challenges in accessing education experienced by Veronica and Tony. The general assistants' work was described in section 6.1. Basil was much respected in the community and an elder in a church. Natasha and Deirdre tended to get caught up in disputes between clinic and day hospital, like Tony and Veronica.

The issue of scope involving the general workers came to the fore at the meeting on 2nd March, 2000, with management. Sr Hunt took the opportunity to voice her pet hate of general workers. This was a good example of both hidden transcript and disguise/anonymity strategies of resistance being used:

I want to ask something. Are the general workers and assistants integrated? So when Deirdre [day hospital] is off can Natasha [clinic] do her work? (My field notes, 2000)

She used this comment to disguise and deflect attention away from the nursing staff while also taking the opportunity to criticise the (what she perceived as poor) performance of general workers. As discussed in section 5.4, she might not have realised the tension her comment would create between the clinic and the day hospital staff.

Veronica, Tony, Natasha and Deirdre, together with Mrs Theunissen from reception, responded to the facilitated integration process and their role in the disputes between the clinic and day hospital under the leadership of Basil. All initially used the disguise/anonymity strategy. Basil tried to involve the trade unions when the facilitated process began. This act of self-assertion by Basil falls under the hidden transcript strategy. However, the trade unions were unsupportive. Then, the general workers used the strategy of being absent at meetings. However, the risk of this strategy was shown at the 2nd March, 2000, meeting when threats (real or not) were made to jobs, particularly of the general assistants. Consequently, the general workers changed their tactic to false compliance. The involvement of all support staff in the integration of the patients' folders suggested to management that the general workers were willing to comply with the facilitated process. This involvement showed also that the general workers were willing to work as a team, unlike the nursing staff. The general workers' strategies hid their frustration with the process: the fear they must have felt when their jobs were being threatened. By being seen as good and compliant workers, perhaps they felt management would be less likely to consider firing them. I think that Dr Lennox's tactic, whether intentional or not, did indeed work and brought some solidarity to the clinic and day-hospital staff.

Training needs 1: in-service training

Training needs associated with new tasks or roles.

This quote, from the Development Plan written by Yvette in October, 1999, raises one of the decisions staff were expected to participate in: training (Owens, 1999b). Training

was pivotal to making integration work through creating multi-purpose staff. The staff recognised this need and requested training during meetings. At the March 2nd meeting, Mrs Theron said:

You know what the problem is: number one is in-service training. At SPM (clinic) we need a little training. We are just out of it but at PAWC (day hospital) they have to learn a lot.

Mrs Theron raised the issue of training several times during the facilitated process. She insisted that the clinic staff could have easily learnt the tasks of the day hospital, whereas the day-hospital staff needed much more training to learn the tasks of the clinic. This comment feels pivotal in highlighting the vast differences between the two services: not only their managing authorities but also their activities. In reality, two vastly different teams existed in Paradise Park, who would meet accidentally because they worked in one building.

During meetings, Mrs Theron focused on the need for in-service training for the provincial authority staff members until a trainer came to the clinic and day hospital. The work done at the day hospital was part of all their training as nurses while the work the clinic nurses do are curative specialisations in tuberculosis, family planning and child health. She felt that the only problem was that it had been a long time since any of the clinic staff had done that type of curative nursing work. A good example of this is Dorothy Trytsman. My fieldwork notes describe her character as a mix between soft and strong. She could be quite intimidating but mainly she was very quiet and loved to talk about her travel and working in England when she was young. Compared with the other two staff members of the clinic, she probably knew the least about various topics in nursing. She was much older than the other staff members, close to retirement and quite set in her ways. She focused mainly on family planning and she lacked a specialisation, unlike Mrs Theron or Mandy Stuart. If integration had occurred, Dorothy Trytsman would have had the most to learn about the tasks of the day hospital. She knew her ability to learn new things was limited. For example, she refused to learn how to insert an intravenous drip at a training session.

During the first half of 2000, Yvette organised a week of training for staff from both services. Unfortunately, the training was halted after one day because the trainers walked out, complaining of the uncooperative nurses. This incident is a good example of the hidden transcript strategy. In public, nurses asked for training; however, when it was organised they did not cooperate. This strategy allowed the nurses to assert themselves when managers are absent, and to show their anger and frustration.

Training needs 2: multi-functional staff

Training CNPs was another example of the preparations to create multi-functional staff. Sr Norman and Mandy Stuart were chosen for training. Mandy Stuart was a young Coloured woman with a good education. I am uncertain why she accessed education more easily than other Coloured women, but I can extrapolate from what I knew of her personal life. She trained as a nurse at Somerset Hospital, residing on the hospital grounds (and therefore avoided a daily commute). She then married quite young to a man who was a bookbinder. His skills in this profession proved lucrative for the couple. They bought a house close to the Southern suburbs (although still in a Coloured township) and two cars. I believe she was able to travel to get a more specialised education while her children were still young. Her better access might also have been related to possibly being from a more middle-class family who might have had more access to finances and living in a better location. I remember her telling me once that her father owned his own company, which might have been in building. Her husband as an independent freelance worker would also quite likely fall under middle-class when she married him. She specialised in paediatrics, but she takes the overflow of family planning patients at the clinic. She wanted to advance her career and she was always ready to expand her knowledge.

Mandy Stuart ended up at Paradise Park at the birth of her last child around five years ago. In this short time she has got to know the lives of many of her patients, such as the births, deaths and illness in their families. She was very obviously pro-active in caring for her patients. For example, she would save time by applying dressings to her patients

rather than referring them to the day hospital. She helped out during emergencies, and transported her own patients to the hospital in Fish Hoek. She emphasised that she was very flexible and that she was not opposed to integration. She felt that her colleagues at the day hospital and clinic should put the community first. She fiercely disliked inflexibility and injustice to others. She was fairly quiet at meetings but showed her support for the process very clearly by distancing herself from the disputes between the clinic and the day-hospital staff at the second workshop:

We should accept it. We are serving one community. Let's not make ourselves unhappy (Mandy Stuart).

Her positive attitude, her ability to learn (shown by her specialisation), and her age, I believe, led to her being chosen for the CNP programme. However, her selection created problems. Mandy and I were implicated in a rumour after her selection became known. I wrote the following at the time:

I arrived today to find Mandy very upset. A rumour had been started trying to make Mandy look bad. I was implicated in this rumour. If this rumour were to reach Mandy's spouse [it] would make life difficult for her. Mandy has been moving ahead, perhaps at the expense of other staff members. (Fieldwork diary, March 2001)

As Scott (1985) highlights, gossip is part of symbolic resistance and it is an example of the disguise/anonymity strategy. Gossip is told about an absent third person and takes on a life of its own while the original teller is forgotten. Scott states that gossip is an indicator that a rule or norm has been broken. The norm or rule that is broken is not necessarily clear until it is broken. In this case, Mandy was perceived as having abandoned the other staff at the clinic by accepting the CNP training from management without consultation or a transparent selection process.

I, as the researcher/co-facilitator, was also implicated in this rumour. The incident occurred a few weeks after the final meeting of the pilot project at which the end of the project was announced. As the facilitated process had ended, I felt quite without focus

and had taken to spending most of my time in Mandy's treatment room. Section 6.2 discussed my positive attitude towards the clinic and the clinic staff. I felt the same towards Mandy and since she and I were the same age, the choice to spend time in her treatment room was fairly obvious to me. Therefore, I changed my previous approach of trying to give all staff equal attention. I can deduce that staff thought I was breaking two rules. First, I was associated with the facilitated process and its end. As a facilitator, I promised to help the integration process go smoothly and make it work. Second, I was no longer acting as an impartial facilitator. As a facilitator I had promised, as an unwritten rule, to maintain confidentiality. By not sharing my attention with a number of people I broke the rule of being an impartial facilitator. This could have influenced any findings presented in this thesis from during the time of this breach of rules. It has to be noted that this happened very near the end of the facilitated process.

Dr Uys would have been the most affected by the introduction of CNPs. I believe she thought she would be mostly unaffected by the integration process. She was present at integration meetings, but spoke little. She kept herself to herself and I seldom saw her at the Paradise Park facility, except during one short tea-break. She had worked at Paradise Park as long as Mrs VTheron and she knew the stories of many patients' families. Dr Uys had a disability and was missing part of her right arm. Despite this, she managed her job. She was quite likely working in a good organisation as a high-pressure job in a hospital would be difficult with only one arm. At Paradise Park, Sr Norman was available to do tasks such as taking blood pressure, applying bandages, and giving injections. The training of CNPs is mentioned for the first time at the meeting of 2nd March, 2000. I believe it was also the first time Dr Uys understood how she would have been affected by integration. During the meeting, Dr Cabral said:

What we would like is to have a clinical practitioner, so that Dr Uys is not so busy. She could go to Numzamo³³ and spend some time there. She can give more care to his patients. A clinical practitioner could sit with the doctor and learn and take over cases.

³³ Numzamo was an informal Black settlement nearby.

The idea was presented very well as it suggested the doctor from the day hospital would have more time with his patients. However, the message behind the idea, which the doctor caught, is that eventually her role would be superseded by CNPs, and she would have to start moving from clinic to clinic or even start working at a hospital. Her attitude to the integration changed from uninterested to agitated over her own future. I think Dr Uys' shift in attitude occurred just before the 2nd March meeting. Before this meeting started, staff were milling around and talking. Most discussions were convivial and friendly with one exception: Dr Uys is talking to Mrs Ysel in the living room area. Dr Uys sounded angry and upset. She was attacking Mrs Ysel because the provincial authorities had organised a teambuilding day but did not invite the local authority staff. Dr Uys said that this activity was strange since both services are supposed to be cooperating. Her aggression really surprised me at the time. The word attack is used above because it matches the word I recorded in my notes from the meeting. I wrote then:

I wonder why she feels this so strongly. She really does sound angry and upset and this meeting does not exclude her. (Fieldwork notes)

Until the training of CNPs was mentioned, Dr Uys thought that the integration would not affect her. Not long before this meeting, the two selected nurses had started their training and they would be ready to relieve Dr Uys by the end of the year. I think she was frightened about what would happen to her then. When the staff were asked at the start of the meeting to comment on the integration process so far, Dr Uys commented on the teambuilding day again:

I still think it is strange. Team-building for the district but only for the day hospital and not the clinic.

Now the facilitated process is over and this really is not a big problem anymore but she keeps focused on it. On the one hand, this is the rupture-resistance strategy in which she made her anger public. Also, I think it demonstrates when resistance is not that straightforward. She was angry about something else but she hid this using her anger,

suggesting the dominance strategy of concealment. By mentioning in public that the clinic was not invited to the teambuilding day, she could have been trying to get the clinic staff to respond. If clinic staff complained and were angry with the area manager about not being invited, I cannot see how this would have benefitted Dr Uys' working relationship between her and the CNPs. Considering this from this angle, could Dr Uys say she is angry about the training of the CNPs? She was the only doctor at Paradise Park and CNP training is the highest-level training a nurse can achieve. If she were to voice that she is angry about the CNP training openly, this would not likely be acceptable for the nurses. So I would suggest she latched on to the only thing she could to show her anger.

Training needs 3: the facilitator/magician

As they did for the name change of the services, Yvette and management chose the two staff members for CNP training. Staff were not consulted, going against the promise of consultation. This approach could have undermined Yvette's facilitator/magician role. I started wondering if there was more to her choice not to consult the staff. . In March 2000, the facilitated process had lasted for five months and little had happened. I can imagine both the NGO and perhaps the DoH would be pushing for more progress. It is almost as if there had to be some tangible progress from the process. Concurrently at the same meeting, Dr Cabral's idea for the clinic manager did not proceed. I am uncertain if these two events were related: I think that they were not. The training of the CNPs is one decision that would have needed the support of both Dr Lennox and Dr Cabral. It is a decision they could take in the functional integration. Most likely both managers and Yvette would have viewed CNPs as a tangible activity representing progress, which could then be shown as such to higher management and the SAHA.

6.5 The community

Who will ask the community about what they want and how they feel? (My field notes, 1999)

The community has not been discussed much except in section 6.1. It feels a little awkward to discuss the community in this chapter, which focuses on staff. As will be shown, the community played a very small role in the integration. This is most likely because the aim of the project showed the integration process had an internal (that is, service-based) focus from the start (see section 4.4). Therefore, while not warranting a full chapter, the community's resistance response to the process makes it appropriate for this chapter. I use data from my own community research, with some literature analysis, to support the discussion of community participation as envisaged under PHC. This section will also refer to the discussions in section 3.5 on Coloured people and their image in the media.

The question in the quote above was asked by Paradise Park staff at the first workshop. It is a good question, particularly since the aim of the project had an internal focus and the community was seen as being served and reached out to. During the project, the community was spoken about but never implicitly or explicitly invited as a partner in the process. When I did my community interviews and observations in 2001, I found that the project had not been publicised or introduced to the community in any way. One resident expressed this surprise, after the project had been running for a year:

Really? Dis die eerste keer ek daarvan gehoor het.

(Really? That is the first time I've heard of it.)

This is the extent to which the community was involved in the pilot integration project. However, some evidence exists on the Paradise Park community's general involvement in health interventions. The following quote is from a presentation at a Healthy Cities launch meeting in 2001³⁴:

34 Healthy Cities, first developed by the WHO Regional Office for Europe, focused on tuberculosis and waste management in Paradise Park. A task group had conducted a health survey to decide these two issues. In this meeting, the health survey was presented and the foci introduced.

Hoekom kom jy engels praat in Paradise Park? Hoekom is mense nie van die begin betrokke nie? Daar is werklose mense hier. Hoekom is hulle nie in diens geneem vir hierdie taak nie?

(Why do you come to Paradise Park and talk in English? Why are people from Paradise Park not involved in this project from the beginning? There are people unemployed here. Why are they not employed for this?)

Neither Yvette nor I were involved with the Healthy Cities initiative in Paradise Park, but we were invited to the launch. The woman's statement seemed to me a prime example of Scott's rupture strategy. The meeting was presented in English, in the Township's Multipurpose Centre. The origins of Paradise Park help explain this rupture. Section 3.3 described a community created through forced removals and living in virtual isolation from the major amenities, potential work places and 24-hour emergency and specialist health care. Geographical isolation, a shared history and the subsequent need for self-reliance created a distinction between Paradise Park residents and people from up the line. This was fortified by an external isolation created by a portrayal in the media of Coloured people, including those from Paradise Park, as drunk, criminal, ignorant and vulnerable (Western, 1996). This portrayal as weak and powerless, stemming from early colonialism and Apartheid, created an image of the Other from the public arena. Thus it is unsurprising that Paradise Park residents make many references to outsiders coming in to lead health interventions:

It is not easy to do that [getting people to participate]. It [intervention such as street clean ups] is for Paradise Park people but people come in from outside. They do not know the people. (Paradise Park resident, March 2001)

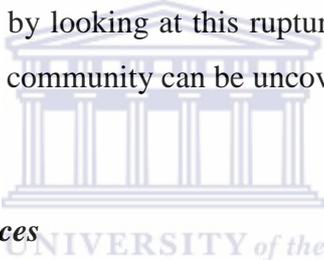
Similarly resentments were frequently expressed about outsiders coming in to Paradise Park do jobs, which similarly skilled residents could have done:

Why do they not give the job to people of Paradise Park? Why do they have people from up the line? (My field notes, 2002)

At the first joint planning meeting one of the workgroups, which included nursing staff as well as middle and higher management, showed their awareness of this issue:

Too often someone from above comes in with no idea of community. These people should train on grassroots level. So that they can run the project themselves.

The quotes above show much resentment about outsiders coming in to change things. The sentiment behind the woman's outburst at the Healthy City meeting must have been spoken often outside the gaze of those in power. As discussed previously, instances of open resistance are rare and can be dangerous, as has been shown in the history of South Africa. Not only is the oppression from the Apartheid era still fresh in the minds of Paradise Park residents, their subordinate position is still reproduced in the media. Resistance is hidden and enacted daily through more subtle strategies. Sometimes resistance does materialise and by looking at this rupture of what is normally a hidden transcript, the real voices of the community can be uncovered.



Community use of health services

During my fieldwork I asked members of the community about their health and health-seeking behaviour. I felt this was important for two reasons. First, I wanted to know what role the clinic and health centre played in the community. Second, PHC entails community members taking responsibility for their own health. I wanted to know what they were already doing at present. Unsurprisingly, most people expressed the following type of view on the Paradise Park clinic and day hospital:

I can't go nowhere else. (fieldwork notes)

These services are the only ones easily accessible, given the limited mobility of residents of Paradise Park. Access during the evening and weekend would have been difficult and consequently a number of people suggested a 24-hour service was needed in Paradise Park. But perhaps more importantly, the overall consensus was for better

transport to False Bay Hospital³⁵. My experiences on fieldwork suggest that ambulances often did not arrive despite the requests by phone of Paradise Park nurses or doctors. Nursing staff and administrative staff often had to transport patients to False Bay Hospital themselves. Such personal transportation was unlikely outside working hours.

A few people I spoke to used private doctors. Reasons for visiting a private doctor included the doctor being the family physician and the family having medical-aid insurance. However, this quote suggests it is more likely that private doctors were used to supplement health needs not being met by the CHC, due to over-occupancy or inconvenient opening hours:

Once he [my husband] had to go to the private doctor because he could not get an appointment. (My field notes, 2002)

One of the two private doctors I spoke to pointed out that most of his patients were working mothers who visit after 18h00. He stayed open until 19h00 during the week and he was available on weekend mornings. The other doctor has similar opening hours. The doctors also see the people working at the dockyard and those with Medical Aid insurance, although this service was reducing³⁶. The doctors also service the overflow from the health centre, the after-hours patients and some emergencies.

Similar reasons were reported for visiting the False Bay Hospital. Some people had illnesses that could only be treated by a hospital specialist. Additionally, the Hospital emergency room provided services when the Paradise Park facilities were closed. People also visited the False Bay Hospital when the Paradise Park day hospital was full:

My husband will sometimes go to False Bay hospital if he can't get an appointment to see the doctor at the day hospital.

³⁵ Suggestions included a dedicated mini-bus for patients.

³⁶ Medical aid is a health insurance scheme in South Africa. One of the doctors noted that the scheme was becoming less popular as fewer employed people could afford membership. A few other respondents corroborated this view.

Fish Hoek Hospital provided services to weekend and after-hours emergencies when the CHC's and private doctors' offices were closed. Several respondents noted that if all these services were open, a hospital visit was preferable to the expensive cost of visiting a private doctor:

[The private doctors in Paradise Park] charge R80 for a consultation, including medication. Unless the medication is very expensive then the patient pays extra.

As a comparison, a fisherwomen told me she might make R15 a day. For her (and many like her), a private doctor would be unaffordable whereas Fish Hoek Hospital would provide care for free if transport could be found. The above discussion has shown the effect the isolation described in section 3.3 has on people; not only for their health care and choices but also their poverty.

In my role as a facilitator, I was asked to do a client satisfaction survey with clients of the Paradise Park CHC. The results are presented here as it provides a fuller picture of health and health seeking behaviour. Apart from the wish for a 24-hour service, responses were generally positive and revealed general satisfaction with the Paradise Park facility.

Respondents in the survey recalled only a few names of staff members. The day-hospital doctor (Dr Uys) and the clinic tuberculosis nurse (Mrs Theron) were recalled often. This is unsurprising as the doctor is a client's primary contact at the day hospital and both these staff members had worked at Paradise Park a long time and spent much time getting to know their clients.

Negative responses were given on the topics of opening hours, waiting times, the pharmacy, and one of the staff members. As the private doctor reported that many of his clients visit after hours due to their work commitments, it is unsurprising that the survey revealed some dissatisfaction with opening hours.

I mapped the client pathways for several days and recorded waiting times. Waiting times for the clinic varied between ten minutes and one hour, and for the day hospital between one and two hours. The pathway of day-hospital clients was relatively longer than that for the clinic, due to the three stages (nurse-doctor-pharmacy) involved and their respective waiting times. This prompted negative responses, particularly for the waiting times for the pharmacy.

Client pathways at the clinic, however, essentially only involved one stage. The waiting time for weighing before the distribution of folders was so short it was not recognised as a stage by the clients. After waiting for the nurse, clients were examined, diagnosed and given medication. No extra waiting time was reported for the pharmacy. Another difference between the day-hospital and clinic is that clinic staff did not take time for tea. The first break after finishing their morning workload was lunch. At the hospital, the doctor's tea-break prompted a similar break for the nurses. This pattern increased average waiting times by 40 minutes for affected clients.



Many problems respondents had with the CHC stemmed from their interaction with reception staff:

I go to the [day] hospital but they are full of nonsense. I can't go nowhere else. I send someone else to pick up my tablets or I go straight through to the sister. X from reception likes to argue with people. ... spoils your day. Other places send an account. Not here: here there is embarrassment. (I35)

This quote not only highlights what would get a client into trouble with reception³⁷, but also to what extent clients were playing the system at the health services at Paradise Park.

³⁷ Three respondents in the client satisfaction survey cited: "harshness and unfriendliness"; "difficult"; and "having moods and gets rude". Other respondents replied that generally, reception was "not helpful"; "not friendly when making appointments"; "upset"; "look 'naar'"

The services provided by the Paradise Park health facilities were not entirely free. People with a certain level of income were required to pay for consultations and medication. However, most people try to avoid this charge and the reception staff was required to enforce the policy. I observed this enforcement was done half-heartedly and it mostly ended up as an embarrassing situation for everyone involved. Some reception staff members felt frustration with their job and felt mistreated by the system. This frustration was expressed in shouting at clients and telling them off for being late, not having an appointment or not hearing the receptionist when called.

The extract from the quote, “I go straight through to the sister”, shows how clients did play the system. I expected clients to enlist the help of Natasha, Deirdre or Basil (fellow residents from Paradise Park), but some patients entered through the back door and just walked straight through to knock on the door of a nurse’s treatment room. The nurse would say, “Alright, go to reception and get your folder.” This implied that the client had bypassed the reception initially, but now with the nurse’s approval, the client could retrieve their file from reception. This bypassing worked at the day hospital as well as the clinic, and I observed its occurrence at least once a day during fieldwork.

Community use of alternative medicine

I also investigated alternative medicine such as over-the-counter medicine, indigenous medicine and prayer healing. Section 3.4 highlighted that with a shift to preventive services under integration, nurses would need to engage with different forms of medicine. I wanted to measure the prevalence of alternative medicine use in Paradise Park. Close to half of the respondents in my community research mentioned use of supplementary health care, be it over-the-counter medicine, or indigenous plants.

(unfriendly); and “friendly unless people are rude to them”. The community research recorded 18% of respondents mentioning “rudeness” or “unfriendliness”. Individual staff member were often identified.

Over-the-counter drugs from pharmacies

These included pain, cold and cough remedies³⁸. Two respondents mentioned buying cough medicine because Paradise Park health services no longer dispensed it. Moreover, respondents bought natural remedies from the pharmacy such as arnica, Bach rescue remedy and Dutch medicine. Dutch medicine is a brand of over-the-counter natural remedies, which aid minor ailments such as colds, coughs and influenza-like symptoms³⁹.

Indigenous plants

Around one third of all respondents reported using herbs as supplementary medication. Use of herbs was by both sexes, among people of all ages and originating from all areas in Paradise Park. The most popular herbs were indigenous plants such as *Wilde als* (referred to as *Als* by the respondents), *Buchu*, *Kruisement*, *Wynryk*, Guava leaves, *Wilde dagga* and Kenneth lily⁴⁰. These plants were used to prevent colds and influenza, or to cure problems such as stomach cramps (including period pains), inflammation or chronic illnesses such as diabetes and high blood-pressure. Special procedures were needed for procurement and preparation. The plants should be picked dry, rather than wet from rain or dew. The plants should then be prepared by infusion and drunk as a tea. The preparation also can be used in a pack after decoction. Ferreira et al. (1996) report that the use of indigenous plants for medicinal purposes finds its origins in Khoisan medical knowledge. The early colonists used this medical knowledge to develop *bossiesmiddels* (bush medicine).

³⁸ Pain medication usually is identified by its brand name, such as Panadol and Dispirin.

³⁹ Respondents reported buying red lavender, ginger, *versterk druppels* (strengthening drops used for stress and depression), peppermint drops and *bors druppels* (chest drops).

⁴⁰ *Wilde als* (*Artemisia afra*); *Buchu* (*Agathosma* species); *Wynryk* (*Ruta graveolens*); *Wilde dagga* (*Leonotis leonurus*) (Ferreira et al. 1996). Kenneth Lily was mentioned to me by a number of respondents and shown to me in their gardens. I think this might be the bush lily or *Clivia miniata*. I was told the leaves could be used for earache. I could not find any references to the use of this plant for this ailment. Veale et al (1986) do describe it as being used to induce and augment labour.

The plants were found or bought in several places in Paradise Park, including grown in a personal garden, picked on the mountain, or bought from the Rastafarians⁴¹. One respondent said “guys come around” the houses in one area to sell herbs, which indicates both the demand and supply methods. A group of Rastafarians lived on the mountain at the top of Paradise Park, behind a cemetery. Their fires often were visible when driving by on the road. However, the herbs usually are bought from Rastafarians living in the town of Paradise Park. Most areas in Paradise Park had a house occupied by Rastafarians. One person bought from a stall run by Rastafarians near Wynberg station. The Rastafarians often sell bundles of herbs for one particular illness, which might be prepared individually for a client. Purchase cost was positively related to the difficulty in sourcing the herb.

Probably the most intriguing part of the use of herbs is the transfer of the knowledge. Ferreira et al. (1996) note that these indigenous medical practices have spoken-word tradition and there is “cultural transmission of the practices and remedies from one generation to another”. In the community research, many respondents reported the knowledge was *ou mense se raad*⁴². Part of the quote from section 3.5 adds:

When we were sick my father would make us herb drinks. For infections, for the measles, to sleep *lekker*⁴³.

This man was a farmer near Noordhoek before being moved to Paradise Park. The following quote, however, is from men from Simon’s Town and suggests another manner of knowledge transmission:

We used to work in the mountains. And in the water at the dockyard. Then we used it [a drink made from parsley and wild garlic which is boiled] for flu prevention.

⁴¹ Seven people reported buying herbs from Rastafarians in the neighbourhood. Three picked herbs on the mountain. Five grew a bush or tree in their own garden. Four received herbs from friends who grow it in their garden.

⁴² Literally ‘old peoples advice’ (I62), or the variant ‘*ou mense se raadjes*’ (I80).

⁴³ ‘*Lekker*’ is an Afrikaans word meaning ‘good’, ‘well’, ‘nice’. This word is used to describe many different things, such as sleeping well, good food or feeling good.

One of the interviews with Uncle Thomas, a key respondent, revealed how the Simon's Town dockyard and the men's knowledge of herbs are connected. Uncle Thomas said they used to have to clear the firebreaks on the mountains. He would form teams of men. While working, they would identify and name a plant, suggest what it could treat, and how it would be prepared. He said the men would teach each other, regardless of age. When I ask him if women also held the knowledge, he said:

I don't think women are good with plants. If you get a woman that puts a plant in, it dies. Only sometimes it will grow well.

Ferreira et al. (1996) discuss the use of indigenous plants by older Coloured people in the Western Cape. My data from Paradise Park suggested that herbs were used by all ages. The argument that Ferreira et al. (1996) make is that older people turn to indigenous plants because they distrust biomedicine and its apparent inefficacy in treating chronic illness. However, although herbs are used to treat chronic illness, the community research suggests they are much more commonly used for illnesses that benefit from home treatment such as colds, influenza and cramps.

Prayer healing

I think prayer and prayer healing was common in the Paradise Park community, although it was mentioned only twice in the community research. The research-question guide omitted a direct question asking about the use of prayer in healing/health. However, the manner in which prayer healing was referred to indicated its significance in the community. Additionally, both respondents were respected members of the community. One was an elder in a large church and the other spoke of his conversion to Christianity. He thought he did not need herbs or medication, as he trusted in the Lord to keep his asthma under control:

Three years gone I repent, I came to the Lord. (I78)

Only if you are a true believer you can be healed. People who do not truly believe cannot be healed. Their belief has diminished. (Steve, 4 July 2002)

Prayer healing in Coloured communities needs more in-depth research to explain its significance in understanding and treating illness.

In summary, I think that alternative medical choices were prevalent in the Paradise Park community. However, the nurses at Paradise Park dismissed this finding when I shared it with them. Nurses in the multi-purpose services would have to engage with alternative medicine, and section 3.4 noted that radical changes would therefore be needed in their perceptions and attitudes.

6.6 The facilitator/magician and the community

A still unanswered question for this chapter is why the community was not invited to take part in the facilitated integration process. Section 4.3 presented Yvette as ambitious and wanting to succeed. She was meticulous in preparing for the process. Her analysis of previous integration projects must have identified community non-involvement as a reason for failure. The project documents she prepares for the Paradise Park Project mention the community, but once the project starts she fails to implement any form of community participation. The discussion of managers in Chapter 5 and staff in this Chapter have shown that she must have been very busy managing the project behind the scenes and in the public eye. So with all these ongoing activities, and the internal focus of the functional integration, she might have merely forgotten. However, the discussion in section 4.2 might mean that she realised, from her analysis of former projects, that meaningfully involving the community would have been more of a challenge than she could handle. The launch of the Healthy Cities initiative would have reminded her that the community could be a very difficult role player.

Successful implementation of community participation has been reported in a number of South African provinces within the implementation of the legislated health reforms. The Free State and Limpopo have successfully strengthened community participation at

facility level (Department of Health, 2004). The North West and Northern Cape report that involvement of local municipal councillors has greatly helped improve health services (Barron and Monticelli, 2003). The Eastern Cape has found that their functioning clinic committees involving community members improved tuberculosis care through the training of DOTS volunteers (Barron and Monticelli, 2003). On the other side, Kwazulu Natal indicates more needs to be done (Department of Health, 2004) and the 2008 *South African Health Review* identified community participation in PHC as one of the remaining challenges (Barron and Roma-Reardon, 2008). Although community participation is celebrated as a vital part of the reforms, the reasons for lack of implementation of community participation are not expounded.

Success and challenges are also reported on a programme basis within PHC. Mosavel et al. (2005) reports successful involvement of community members in developing a health promotion programme focused on cervical cancer screening (Mosavel et al., 2005, Wrong et al., 2005). Another project reports on successful community participation in identification and prioritisation of health needs in the Western Cape province (Hildebrandt, 1994). A project studying the impact of using community engagement in treating patients with tuberculosis found that community based programmes produced better health outcomes (Kironde and Kahirimbanyi, 2002). Challenges identified included actually moving beyond regular stakeholders and engaging a variety of community members (Mosavel et al., 2005), a need for vast investment of time and resources (Hildebrandt, 1994), and requests for remuneration of volunteers (Kironde and Kahirimbanyi, 2002). These reports do show a careful consideration of operationalisation and implementation strategies of community participation.

Literature suggests that community participation can work, but five questions need to be considered:

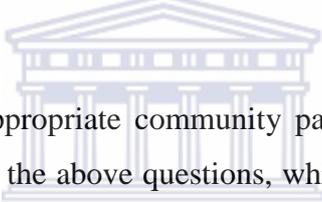
- a) How is community participation to be brought about? It might not just be a question of educating the community about the benefits or using some type of pressure (Madan, 1978). Attitudes towards participation have to be considered.

My research suggests that by participating in interventions can mean a person is admitting that something is wrong with their community, and they fear standing out.

- b) Which issues will the community be involved in? Stone (1992 p.412) identifies five levels of involvement ranging from receiving health services and education to involvement in “program planning or in translating their own felt needs and interests into a true grassroots development”. The pilot project documentation emphasised community involvement in programme planning and implementation. This activity was not operationalised, however, and it lacked clarity on which issues the community would be involved in.
- c) Who will be representing the community? The feelings of outsiders coming in to make changes or leading interventions and not employing residents is a priority concern. Who might be most suitable to represent community interests? The answer to this question requires acknowledging issues of pressure, control, motivation and traditional notions of authority (Madan, 1978). The risk is that certain people would be included while others are excluded (Reidy and Kitching, 1986, Askew and Khan, 1990, Jewkes and Murcott, 1998, Boyce, 2001). When asking about community involvement, I found often that one man with a good education and his own agenda volunteered for membership of committees. However, would this person be the best representative for the community, and should one person always be the representative? For instance, will young people and fisherwomen be part of committees, or will it be those people active in politics in the district? Or someone from Mountain View?
- d) What does the community need to know for this involvement? Considering this question seeks to avoid the situation Uzochukwu et al. (2004 p.162) found where “the community were willing to participate, although they are not fully aware of what they were expected to participate in”. Madan (1978 p.617) states that “citizen’s representatives do not have enough knowledge about technical

matters and of bureaucratic procedures to be able to seriously disagree with the experts or make them change their mind.”

- e) Is community input always welcome? This question should be considered from the perspectives of both the health professionals and the community. Literature shows that a top-down approach is unappreciated by a community. However, community members “tend to want responsibility to remain in the hands of the medical professional” (Rifkin, 1983 p.1494). In terms of the health professionals perspective two things are needed. First, health professionals need an understanding of the community in general. Second, the exact levels of community involvement that would be welcome needs to be determined. Considering the discussion in section 3.3, image might be an issue. If Coloured people are portrayed as irresponsible, how would this affect their participation?



To achieve meaningful and appropriate community participation, Yvette would have had to consider and address all the above questions, while performing her usual role of leading the integration project. She might have realised the difficulty of this challenge and just left the community to one side to concentrate on the facility.

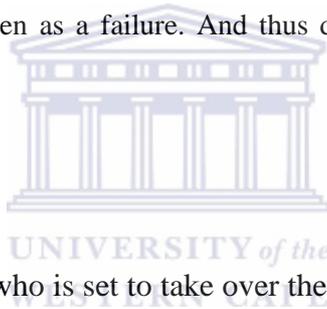
6.7 Conclusion

My analysis of the staff and community has shown how the concepts of dominance and resistance can be useful in analysing their response to the facilitated process. However, it also shows that factors such as race, gender and age can influence their responses. In the next chapter, the final part of the facilitated process will be discussed and analysed: the end of the project.

Chapter 7 - The end of the project

In this chapter I will recount the events surrounding the end of the project. This chapter will depend again on the concepts of dominance and resistance for analysis. This chapter also includes a report on the Paradise Park facility from 2006 when I visited South Africa. This report will allow a comparison between the facility during the facilitated process and 3 years after the end of the process. The end of the project started with the following phone call:

On the phone, a few days before the meeting, I was told by Sharon that the pilot is seen as a failure and they want management to take part responsibility for this. I could conclude from this that the official reason is that Sharon's taking over has prompted [the NGO] to review the post and decide to focus on the new Uni-city. Unofficially it could be seen as a failure. And thus discarded. (My field notes, March 2001)



The phone call

Sharon, a colleague of Yvette who is set to take over the facilitation of the integration in the district, calls me a few days ahead of the 1st March, 2001, meeting. I had worked with Yvette during the facilitated process, but I knew of her colleague Sharon, who worked in a similar role. At the time, I was not surprised that Sharon, rather than Yvette, phoned me with news of the end of the project. On reflection, I am surprised. Yvette and I worked together as facilitators, so I would have expected Yvette to have informed me of this important news. The timeline of the meetings helps explain this issue. The facilitated process began quickly with the first workshop and meetings up until 2nd March, 2000. A few meetings occur next, and the second workshop is on the 1st June, 2000. Thereafter, although the facilitated process officially continues, no related events are organised. After nine months without action or meetings, the end of the project is announced.

I did wonder why I was told before the meeting that the project was ending. Of course, it could have just been courtesy, given I was a member of the project team. Considering the discussion in section 4.3 on Yvette's views on myself, however, a different explanation might apply. Her strategy could have been more about controlling my response during the announcement in the meeting. Knowing beforehand would mean less shock on my part. Therefore I would have been available to sooth people, a role Yvette seems to have planned originally for me.

The meeting

Yvette starts the meeting by saying that she has left and that she would like all of us to introduce ourselves for the sake of Sharon, who is taking over from her.

[Everyone introduces themselves.]

Yvette says that the goal of the meeting is to get a sense of where the process is and will go, plus a goodbye. Yvette makes clear that Sharon will be working on a different level: the level of the Uni-city. [The NGO] has decided that since Yvette is leaving and Sharon is taking over, it was time to review the position. This means the end of the guided process and it is now for the management and staff to take it further. This also means that the survey will not be paid for by [the NGO].

[It is clear that this is a total surprise. The shock can be read on their faces.]

Yvette then asks for a chair from the staff and for them to take the meeting further. Sr Norman is chosen. She asks Yvette what should be on the agenda:

- Update of the integration process
- Where it should go (Meeting minutes from fieldwork notebook).

Until this point the story of the integration project was a carefully planned process and a pivotal meeting on the 2nd March, 2000, at which managers withdrew and staff members resisted. The facilitated process continued with a second workshop and a few meetings until 1st March, 2001. On this date, the process abruptly ended.

The 1st March, 2001 meeting was called by Yvette for all staff members. The area managers from both services attended; Dr Cabral, Dr Lennox and Dr Davisson were absent. Only a few staff attended: Mrs Theron, Veronica, Natasha, Suzanne, Dr Uys, Basil, Mrs Theunissen and the new pharmacist. The atmosphere before the meeting starts was fairly relaxed. Yvette then started the meeting (summarised in the above quote). The Paradise Park staff clearly were surprised and shocked that the project was ending. Yvette then asked for a staff member to chair the meeting: Sr Norman was chosen. Sr Norman then proceeded to ask Yvette what should be on the meeting agenda.

In section 4.3, I showed that the role of the facilitator is close to that of the magician and the process of integration followed, until this last meeting, the first two stages of a rite of passage which were guided carefully by the facilitator/magician. At this stage of the facilitated process, the end stage would be expected. However, similar to the launch lunch, I would have expected another ritual event to mark the end of the planned process. It occurred to me that Yvette was following the three stages of the rite of passage in one swift (no more than five-minute) speech. She separated the staff from the old status of being in the facilitated process by introducing Sharon, telling staff she was leaving and that her departure required the facilitator's role to be reviewed. She then stated that this meeting was the end of the process, and management and staff would be expected to take it forward. This was the transition in which the ordinary (a new characteristic of the facilitated process) was terminated. She then, ritually, handed over the chairing of the meeting to a staff member, showing that staff have to incorporate life without the facilitated process.

Before the meeting Yvette used a legerdemain, despite this taking her briefly out of the facilitator/magician role: she announced her pregnancy. Although the news the project was ending was shocking, the conversation after the meeting focused on her pregnancy. Both Yvette and myself were asked constantly when we would have "a bun in the oven". At the time we had both been married for a few years and the female staff members obviously thought it was time for us to become mothers. This did distract quite a bit throughout the project.

Yvette's final statement that the survey would not be financed, felt out of line with the rest of her statement about the end of the project. All other elements of the meeting had gone smoothly from getting staff to introduce themselves to Sharon to the handing over of chairing. I recall Yvette's final statement as harsh both at the time of saying, and when I read the paragraph above. The statement emphasised to staff the finality of the end of the process. The NGO really is not going to be involved in the facilitated process anymore because, even though they promised, they would not support (e.g. finance) any of the planned activities. Considering this decision from the NGO's perspective: why spend money on a process that is ending?

Sr Norman then took over as chair of the meeting. My fieldwork notes state that she was chosen. The reality was, of course, that Yvette asked for a chair and Sr Norman was the only volunteer. In view of her character (as described in section 6.4), she would have wanted to show that she had leadership potential and stayed cool in stressful situations. Given her close relationship with Mrs Lombaard, it occurred to me that Sr Norman might have known about the end of the process. However, although all area managers would have known the process was ending, Mrs Lombaard retired some time previously and her position was taken over by Mrs Ysel (with whom Sr Norman did not have a close relationship).

Sr Norman's question on items for the agenda is probably the most prominent aspect of my meeting notes. It signalled that although the NGO had decided that staff and management should take the process of integration further, these parties were unprepared for this role. It struck me as almost comical, in a negative way. Yvette had just separated herself from the process completely (by announcing the end of the project and introducing a new facilitator), but she still needed to guide this meeting. She repeated this behaviour during the update part of the meeting by interjecting questions to steer the discussion:

What about the steering committee, is that still functioning?

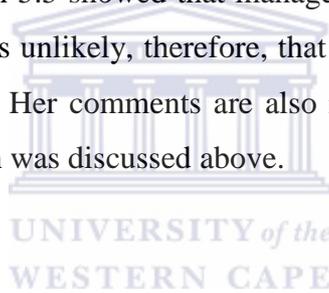
What about the in-service training?

What about the joint stock-taking?

All these questions were raised to guide the staff into thinking what had been done and what still needed to be done. During the second part of the meeting on where the integration process should go, Yvette's focus changes:

You have done so much work. Now it is for management to take it further. The ball is now in the management's court.

Although her initial speech stated that "it is now for management and staff to take it further", this latter statement implied that management really should be in charge of the process now. However, section 5.5 showed that managers had already withdrawn from the facilitated process. It seems unlikely, therefore, that the managers would have been willing to take a leading role. Her comments are also related to the phone call a few days before this meeting which was discussed above.



Response of management

Before discussing the role of facilitators in the ending of the project, I would like to focus on the response of the area managers at the end meeting when staff were told:

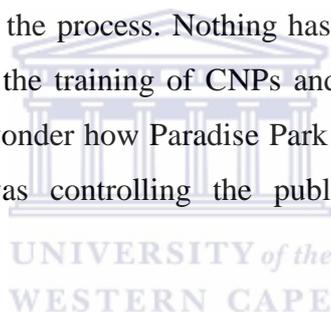
The district is behind. Starting from scratch. Paradise Park is miles ahead with the integration. (Mrs Ysel)

I've seen the process. It is slow and surly with scratches. We must know that that is the process. (Mrs Johnstone)

It should be noted that the managers Dr Lennox and Dr Cabral were absent from this meeting. Although they had been absent from the process since the March meeting the year before, part of me expected them to attend this final meeting. After all, Yvette stated that staff and management would take the integration further. This meeting would have been a good opportunity for management to present a plan or show support for the

next steps. I think their withdrawal from the process reflects the power struggles behind the scenes. I also wondered whether their absence meant they were a little afraid that staff would blame them for the end of the process. The managers knew that the NGO partly blamed them for the failure. Yvette, who was leading the meeting, was due to leave the NGO within days of this final meeting. The managers might have thought Yvette would take the opportunity of the meeting to shift blame from herself to the managers.

Mrs Van Vuuren, the provincial area manager, makes this statement at the start of this section at the 1st March meeting. She described Paradise Park staff as being lucky three times during the meeting. She was a relatively new area manager and seemed to be playing a supportive role in the meeting. It felt as if she was trying to make the staff feel a little better about the end of the process. Nothing has really changed in the facilities during the process except for the training of CNPs and the integration of the clients' medical folders. It made me wonder how Paradise Park could be "miles ahead", as she suggests. It felt like she was controlling the public stage using a strategy of concealment.



Mrs Johnstone, however, has been with the process throughout and her statement at the end of the meeting does not seem to conceal everything. Her comment acknowledged that integration takes time and that it does not happen without people getting hurt. Knowing her close relationship to the clinic staff, I am certain that she did not want them being upset. This interpretation is supported by one of the final comments she makes:

Don't even be afraid to lose your job. We are sparse on the ground (Mrs Johnstone).

This statement suggests that she was taking the job threats seriously, or she was aware that her staff were taking them seriously. She would have been aware that her staff

would have remembered, and be concerned about, Dr Lennox's comment on job security over a year ago.

The facilitator

What I found most puzzling was that between the second workshop (1st June, 2000) and the announcement of the end of this project (1st March, 2001), no project events occurred. In effect, staff would have thought that managers were not working on the integration, as facilitators were not organising or guiding any workshops or meetings. As the weeks went by, and I waited for something to happen, I reduced my visits to Paradise Park as their daily work continued as usual. Up until this point, Yvette has been so dynamic. She analysed former projects, developed a plan for integration of the Paradise Park health facilities, and controlled everything from the choice of the pilot site to the speeches of the managers. The project and its execution both revolved around her. She did not trust Dr Lennox or Dr Cabral to play an active role, and even I was only on the sidelines. Two strong elements supported this level of control: the controlled environment with a captured audience and her facilitator/magician abilities. And then she just stopped.

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The question in my mind is when Yvette gave up. I was not always privy to her discussions with management. It is quite possible that Dr Cabral's outburst about the clinic manager was one small example of the discussions going on behind the scenes. If Yvette was unable to get management to agree to any changes, there would have been little point in continuing the process. Her withdrawal from meetings after 2nd March could have indicated this problem. Management really withdrew also from Yvette. As Yvette said in her speech, she was leaving the NGO. At some point in those nine months, she must have started looking for another job. This was a conscious decision that she wanted to move on from the facilitated process. Was this another indication that she had given up?

I knew that at the time of the facilitated process at Paradise Park, Yvette was working on another integration project in Delft on the outskirts of Cape Town. Delft is very far from Paradise Park. So her disappearance might just have been linked to her commuting to Delft, starting a new project and being unable to commit time to the Paradise Park project. It is also possible that she was working behind the scenes at the time with managers and I never found out about it.

The events of the final project meeting made me question the neutrality of facilitators. Section 4.3 introduced how facilitator/magicians guide and coordinate change. To do this effectively requires the facilitators to work as mediators by positioning themselves as neutral entities. My analysis identified several ways in which the facilitators, including myself, had enabled the managers to use strategies of dominance. Yvette spoke to the managers at the introductory lunch, re-enforcing hierarchy. Both of us had been important in organising the affirming joint-planning meetings. Yvette's document on the steps for integration had allowed the managers to hide behind her and not give any practical help to the staff. I did not question this behaviour in this meeting despite being there, partly, as a facilitator myself. And finally, Yvette and I helped in concealing management's role in the failure of the facilitated process of integration.

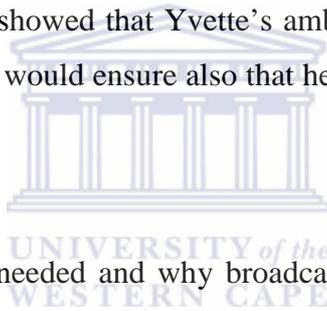
7.1 Evaluation of the project

Why did the project fail? Official and unofficial explanations

What intrigued me the most at the time was that official and unofficial explanations of the outcome of the facilitated process of integration at Paradise Park would emerge. Later, it became clear to me that all reports would have the official version of the outcome. My literature search failed to find any reports about the Paradise Park integration project on the NGO website or from other sources. I am uncertain whether such reports exist, or were just unpublished. Expanding narrative analysis to consider the intended audience and purpose of this message of success in the integration gives some insight into the two versions of the events around the project's outcome. The

official version of events would be broadcast by the NGO, the managers and, by extension the DoH. The unofficial version would not be broadcast but would be known to those parties and myself. The official version would say that a review of the project prompted a shift of focus. Using the word review indicates to those listening that a structured evaluation occurred which informed the subsequent decision. This version makes the decision-maker look competent and inspires confidence that the decision was not whimsical.

What is not being said, i.e. the unofficial version, is that the project failed and management were responsible. No review of the project occurred, and if what I surmise from Yvette's behaviour is correct, the NGO knew for some time that management had been obstructive and withdrawn. No review was needed for the NGO to reach this conclusion. Given section 4.3 showed that Yvette's ambition drove her involvement in the project, the official version would ensure also that her reputation was undamaged by the project's failure.



The questions of why this is needed and why broadcasting success is needed for the intended audience still need to be explored. Considering that the NGO, management and the DoH would have known the official reason, the only possible audience was the staff from Paradise Park (and by extension, all staff in the district). I considered what would have happened if the unofficial reason had been broadcast. Telling staff that a project is a failure could have made them feel very despondent whether they wanted this change process initially or not. At the start of the project, much had been made of the unique opportunity that was presented to Paradise Park with the whole country watching and the cure to failed projects being known. To see this not come true and failing instead would give rise to feelings of dejection at the very least. Then, telling staff that their managers (with whom they still have to work) were responsible would have been infuriating. Broadcasting the unofficial version, therefore, would have been detrimental for the future working relationships between staff and management. The reasons for the end of the facilitated process would have become known to all staff in the district either via questions asked, or by conversations between staff members.

Knowledge among district staff that management was responsible for the failure in Paradise Park could cause unforeseeable consequences. Citing a less caustic reason for failure, particularly one that used a structured review to inform the decision-making processes, is far preferable. Staff would be upset, but not angry.

The action related to the failure of the process is an act of controlling the public arena. Control over written reports and feedback documents and use of words such as review fall under Scott's concealment strategy of dominance. This strategy controls the public stage and conceals the real facts of failure and the role of management in this failure. The use of the word review can be seen to fall under the strategy of euphemization as it sanitised the use of power through obstruction by managers. Euphemization worked in particular to obscure the use of coercion. The staff was coerced into accepting the end of the project by being offered a particular reason. I am certain that staff knew that managers had been obstructive and might well have been responsible for the failure. However, staff had no reason to be openly angry about the manager's behaviour if it was never officially recognised. It also occurred to me that shocking staff supports the concealment strategy. People in shock do not tend to ask questions. If staff had been told about the end of the project first and a meeting had been held after, I am sure they would have asked more questions.

The issue raised in the above discussion is closely related to the debate regarding the dissemination of research findings or reporting bias. The Cochrane handbook for Systematic Reviews of Interventions defines reporting biases as "aris[ing] when the dissemination of research findings is influenced by the nature and direction of results" (Green and S. Higgins, 2011). The Cochrane handbook defines a number of types of reporting biases, including publication bias when research findings are published or not published and outcome reporting bias when some outcomes are reported but not others. McGaurun et al. (2010), focusing on these two types of reporting bias, found in their review of medical literature that reporting bias had been practised on a wide scale for several decades. In a response, in particular, to the publication of Ben Goldacre's book *Bad Pharma* (2012), which brought the issue of the misuse of evidence into public

view, Godlee (2012), the *British Medical Journal* editor-in-chief, pointed out the effects of reporting bias are that medicines are seen as safer and more effective than they really are. Relating this back to the discussion above, reporting bias for interventions, can make integration seem more successful and problem-free than it really is. McGaurun et al. (2010) highlighted two issues reporting bias can lead to for medical interventions: over-estimation of efficacy and under-estimation of safety risks. Similarly, for this pilot project, reporting bias can, for other pilots, lead to over-estimation of efficacy and under-estimation of the challenges.

The evaluation meeting

I have effectively let go and they have let go too. Might be it is not such a good idea for me to come back. What needs to be done now is to focus on the positive and make the next meeting at Paradise Park a task meeting. It might not be necessary for senior management to be there. It might also be good to show they are there. No talking, but actual work. They might be quite scared and what you need to do is have a meeting on a planned change and sit down with them and say, "How do we do it?" (Sharon, 13th June 2001, minutes from fieldwork notes)

Around three months after the 1st March, 2001, meeting when the end of the project was announced, a management meeting was held in the Civic Centre, Fish Hoek. The municipal authority managers were present: Dr Nelson Davisson, Dr Cabral and Mrs Johnstone. I was told Mrs Ysel was invited, but she had a previous engagement. Interestingly no one mentioned Dr Lennox. It is quite likely that he was invited, given Mrs Ysel was. I do not think this was intended to be a municipal meeting only. Of course, it is possible Dr Lennox's lack of invite was caused by his perceived obstructive approach, as Dr Cabral's hidden transcript from 2nd March, 2000, indicates. If he was invited, he could also have had a previous engagement or he might have chosen to ignore the meeting taking his withdrawal from the facilitated process one step further. If he had withdrawn from the process, no reason existed for him to participate in the evaluation.

Sharon and I attended the meeting and Sharon's comment quoted above was responding to a comment made by Dr Davisson. He felt that a closure meeting was needed. He stated that more clarity is coming from the national level in July/August on plans for integration. A new management coordinating team would be ready to address the integration on the other levels besides functional, and the newly-trained CNPs would have to be re-integrated with a new role. Although Dr Davisson suggested that management should take this process forward, Sharon thought that he was asking her to return and coordinate. She made a similar statement twice. She was not directly asked to return, but must have a reason for making it abundantly clear that she would not return. Behind the scenes, she and her NGO must have been questioning whether such a return would be possible.

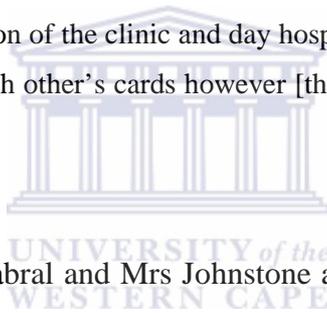
Returning to her quote, she then, to me, clearly responded to the problems highlighted in section 5.5 i.e. the withdrawal of managers and the lack of practical solutions. First, she labelled the meeting as a task meeting, to suggest that rather than indicating closure, the event would represent the beginning of a new direction. Second, she commented on the presence of managers. She mentioned senior management which is interesting as I would have called only Nelson a senior manager. Since she used a plural term, she must have been referring to Dr Cabral and Dr Lennox. By not using their personal names she created a little distance and avoided naming and shaming. Everyone at this meeting knew that Dr Cabral, Nelson and Dr Lennox were absent from the end meeting at Paradise Park.

Sharon then focused on the need for practical support and used the phrase "no talking, but actual work". Section 5.5 highlighted there has indeed only been talk so far. She reiterated again her NGO's view that management should take responsibility for the failure. No one at this meeting used the word failure although everyone in the room would have known the NGO's view on the project. I would almost say that the dominant players created unanimity so they could cooperate. If the word failure had been spoken, I doubt the NGO would have kept working with these managers.

Sharon also engaged with how the staff might have been feeling. First, she questions how the staff reacted to the ending meeting, and then she suggested they might have been scared. She is the only person at the meeting who refers to the staff's experiences. The rest of the meeting discussed service-related issues such as which services were integrated, who was being trained for CNPs, information systems, etc. Even though Sharon was not going to be involved with Paradise Park, she definitely wanted to reflect their side of the facilitated process. I believe that despite the show of unanimity, Sharon wanted the managers to be aware that staff had suffered in the process. As a facilitator, she was an outsider at the meeting. Perhaps her role best placed her to draw attention to the problems that had occurred, and to warn that they should not occur again.

Where is the integration at?

Admin: It [the administration of the clinic and day hospital] is one. They work well together. They can't do each other's cards however [the clinic's and day-hospitals' patient cards].



Continuing the meeting, Dr Cabral and Mrs Johnstone answered the question posed by Dr Davisson: what has changed due to integration? They began by considering administration, a function which was judged to have improved due to integration. The comment about “not doing each other's cards” confirmed my suspicion that the integration of the patients' folders was false compliance by the general workers. My participant observation in the reception area suggested that these procedures were unchanged. Patients' cards could not be completed by the day-hospital staff for the clinic patients and vice versa, which meant that although the folders might have integrated, the procedures to process patients were still separate. So it seemed as though the staff members were complying with the integration but they did not make a real change. However, I wondered how the integrating of patient pathways would be possible since the nursing practice (and therefore patients' pathways) were unchanged:

Nursing practice: is still all separate. They have requested training and clinic staff have been given this training. Dressings etc. But they still all go their separate ways.

I also observed that the nursing practice was all separate as the quote above suggests but the part about the training was only partly correct. Neither Mrs Johnstone nor Dr Cabral mentioned that the trainers left after just a short time and little training therefore happened (described in section 6.4). Interestingly, despite knowing of this failure in training, both choose not to raise the issue. I imagine that they did not want to voice this failure to their boss, Nelson Davisson, or damage the reputation of the staff. Both were concealing facts to imply that staff had cooperated with the training. This concealment also served to maintain their own reputation, as staff refusing training could have been interpreted as a failure by management.

Cleaners are together, says Mrs Johnstone. Dr Davisson asks if they clean each other's spaces. And Mrs Johnstone says yes (personally, I doubt it). When the topic of cleaners comes up Mrs Johnstone strongly asserts that they are together. Dr Davisson then asks for clarification quite specifically.

Given Dr Lennox's comments last year about the jobs of general workers (see section 5.4), I am not surprised that the cleaners were considered at the management meeting. Given Mrs Johnstone's personality where she is usually quite protective and her strong assertion, I believe she was protecting the general workers here, even if the job threat is false. However, once again this could be concealment. Staff not cooperating with the integration project is possibly a management issue, similar to the training.

At the end of the meeting, Sharon reiterated her point about "work, rather than talking". The comment serves as a useful concluding statement, as the Paradise Park health facility was functioning in very much the same way as it had been before the facilitated process began.

7.2 Paradise Park, five years on

In February, 2006, I travelled to Cape Town and visited Paradise Park. The Paradise Park CHC was operating with a skeleton staff⁴⁴ in a large, mainly empty new building. Some of the former clinic staff were still there, although some had moved to jobs in the private sector. For instance I went to meet Mandy, a former nurse at the Paradise Park clinic. She was working as a nurse in a pharmacy in a large supermarket. She was diagnosing and prescribing on her own which, her CNP training had prepared her for. She had a small waiting room and office behind the pharmacy. She told me that she became demotivated by the problems in the health services, and her difficulties working with staff at Paradise Park. Her view was understandable, given the gossip present at Paradise Park (discussed in section 6.4). She told me that her new job paid much more, the commute was quicker and therefore she could spend more time with her children.

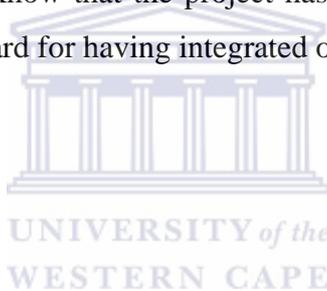
The remaining staff at Paradise Park were ambling along as best they could, offering services much as before, but with fewer staff. Mrs Theron and Dr Uys were present, with a few locum nursing and pharmacy staff. It occurred to me how far removed this was from the envisioned integration.

The new building was a surprise. No building work had begun when I left Cape Town in 2003. I first heard of the idea during a conversation before the start of the 1st March 2001 meeting that announced the end of the facilitated process. Mrs Johnstone, Mrs Theron, Sr Norman and Dr Straus were sitting together around the kitchen table and discussing the need for a better building. Then, Paradise Park was twelfth on the list kept by the DoH to be upgraded. Mrs Johnstone thought that at least R1 million would be needed to do the renovations properly. Three months later on the 13th of June 2001, the issue of renovation was raised again at the management meeting. At the start of this meeting Dr Davisson said that the building will be:

⁴⁴ Staff was two permanent clinic nurses; a temporary nurse; a doctor from the day hospital; a receptionist; an administrator; and two cleaners.

[structurally redone], up to a certain point this year with the planned allocation of R300,000. (Dr Davisson)

This seemed to me, at the time, a great change from the Paradise Park building being twelfth on the list to having money allocated for renovation within three months. Dr Davisson indicated that the money was for this year only. Clearly, more money was found in the subsequent years to construct a new building. This makes me believe that Paradise Park was prioritised by both management teams for this new building. Why was this done? An obvious answer relates to the recently failed integration project and the role of management in this. A less obvious answer might be that it would show staff that management are able to arrange things. It could then have been a show of affirmation to not only to Paradise Park staff but also to the rest of the district. Given that none of the district staff know that the project has failed, the new building could have been interpreted as a reward for having integrated on paper.



7.3 Conclusion

The pilot integration project started well on the 7th October, 1999, but ended abruptly on the 1st March, 2001. Between these dates, the facilitated integration process experienced acts of the facilitator/magician, strategies of dominance and resistance, and finally disintegration. At the end of this, initially, well-planned facilitated integration process all role players had been affected. The managers withdrew around five months into the process and failed to reappear even at the end meeting. The next time staff and management meet is when the managers assert themselves with a presentation of their achievements in integration overall, or personal achievements.

The facilitating NGO withdrew from the process nine months after the last meeting. The lead facilitator, Yvette, moved on to another job. This was not the expected positive outcome for her and her position in the NGO.

Five years later in 2006, the Paradise Park health facility was functioning with a skeleton staff in a very large new building. However, patients' pathways remained unchanged. Fewer services were now being offered to the community.

The community continued as before, with slightly less access to health services, and probably still unaware why this change in access and number of staff occurred.



Chapter 8 - Discussion and conclusion

This thesis aimed to consider the insight anthropology can provide into integration processes in a health system. The previous four chapters have critically explored a facilitated process of integration in an urban setting from planning to evaluation. This final chapter has two objectives: to summarise the findings and critically consider whether the aim of the thesis has been achieved; and to consider the implication of the findings for other integration processes, particularly those which are facilitated. The importance of this discussion lies particularly in the renewed interest in PHC as highlighted by the *2008 World Health Report* (WHO, 2008).

8.1 Summary of the main findings

This section summarises the main findings from the four analysis chapters and will consider some of the strengths and weaknesses of my research design. The main strength of anthropological work lies with its engagement with the context. As highlighted in the introduction (see section 1.2) anthropology explores human experience by considering many aspects of social life. In terms of health reform literature, this approach is very welcome (Blaauw et al., 2003). However it is important to highlight that this thesis provides a more historical view as it took place over 10 years ago. To facilitate this exploration, Chapter 3 'Integration in context: dominance and resistance' presented a framework which contextualised the subsequent four analysis chapters. Chapter 2 built on the concepts of dominance and resistance by engaging with the main critiques of this binary view of power and lack of engagement with other aspects of social life, as Ortner (1995) argues. By fully exploring the historical context, the international arena, the present context and the facilitator, the analysis of the data was considered from the point of view of dominance and resistance while engaging with numerous contextual factors. Chapter 3, however, also highlighted the main limitation of the study: my gaze. Considering the importance of race does not come naturally to

me and throughout the analysis I have noted how this factor might have limited my insight.

Chapter 3 was followed by the four analysis chapters which follow the facilitated process from start to finish. Chapter 4 considered the planning stage and the role of the main facilitator. Chapters 5 and 6 considered the process of facilitation from the perspective of managers, staff and the community respectively. Finally, Chapter 7 considered the end of the project and its evaluation. The main findings from these chapters and the degree to which they have achieved the aim of the thesis will now be considered.

Chapter 4 'Planning for integration' showed how carefully the facilitator (Yvette) planned and orchestrated the start of the process through her analysis of previous projects, choice of site, and the launch. Yvette emerged as the facilitator/magician who controlled the first two stages of the rite of passage (separation and transition) through careful choice of words, magic acts and transforming the spiritual state of staff and managers. What stands out in this chapter is the use of Controlled Space. This is a new concept within the anthropological concept of Space and is defined as the opportunistic use of space to exert control. The analysis used this concept to explore and explain an individual's actions and use of space.

Chapter 4 introduced some of the problems that later hindered the facilitated process. Section 1.1 highlighted that previous pilot integration projects in the health system faced major managerial and organisational challenges, including:

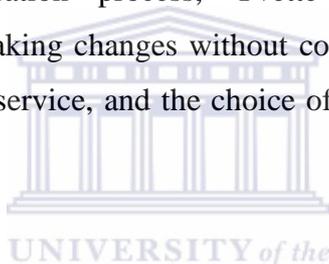
- a) Difficulties in forming one local authority.
- b) Disparities in salaries and benefits between local and provincial authorities.
- c) Staff resistance.
- d) Power struggles between the two authorities.

Throughout the Paradise Park facilitated process, which focused solely on functional integration, two different management and administrative systems were in place. Challenge a) above, therefore, was not addressed at the start of this facilitated process. Similarly, challenge b) was out of the control of the facilitator. Yvette therefore, could only focus her facilitation skills towards challenges c) and d). Through her facilitator/magician role, she clearly tried to counter resistance by providing consultation and support for the staff. Yvette also seemed to understand that the role of the managers would be pivotal and her fear of their lack of support was shown in her evaluation of their roles (see section 4.5) and her efforts to control both the location and the speeches of the project's launch (see section 4.8).

After the carefully orchestrated planning of the project, the process of facilitated integration was considered from the perspectives of three groups of actors: management (Chapter 5 'The role of managers in the integration'), staff and the community (both in Chapter 6 'The facilitated process of integration: staff and the community'). Although the managers unanimously seemed to support the process at the start of the project, power struggles very soon emerged, as the facilitator feared. Most intriguing here is considering the power struggles between the two managers from the two authorities. The analysis showed that this power struggle was not just obstructionism fuelled by the fear of loss of power. By critically analysing minutes from meetings and applying the strategies of dominance, it became clear that particularly one of the managers recognised the realities of the change process and the limitations of focusing solely on functional integration. These realities, combined with the manager's background, informed his choice of strategy. When the managers realised (which one did from the start) that they lacked the power to make any changes, both exited the facilitated process. Their exits were the first signs of the eventual failure of the project. However, I should acknowledge that I knew little about the work to facilitate the integration process Yvette might have been doing with managers outside the Paradise Park meetings.

Chapter 6 then looked at the process from the point of view of the staff and the community. This chapter showed that staff resistance indeed played a major role in the

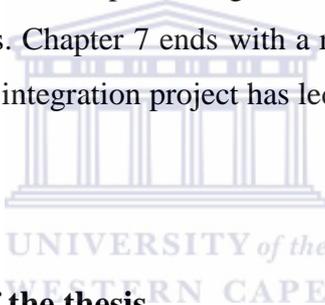
failure of the project. Similar to the power play of management, the analysis showed what motivates people to resist and their choice of resistance strategies. Determinants included a person's background such as age, position in the hierarchy of the health system, historical access to education, and gender. What is most striking, and I do not think I have highlighted this enough, is that staff members continued their daily practice (as defined by their job descriptions) during the integration process. The facilitated change process and the resulting uncertainty staff felt did not influence the health services provided to the community. Although Yvette did her best to address staff resistance through support and consultation, these efforts were insufficient. Several structural (and therefore mostly not addressable) issues interfered, including the choice for functional integration (see section 4.4), the lack of clarity on what needed to be done to accomplish integration (see section 4.6) and the lack of staff power to make any changes. During the integration process, Yvette also undermined her own facilitator/magician role by making changes without consulting staff; for example, the change of name of the health service, and the choice of CNP trainees from among the staff.



While staff consultation in the integration process was limited, consultation with and participation by the community were absent. This is due to the lack of involvement of the community played in the pilot project. Instead, I depended on acts of resistance and insights into community participation from several sources. Also, I witnessed one act of resistance which gave me some insight in the possible responses by the community if they had been involved. The Paradise Park community's experiences of outsiders coming in and taking control was rooted in the factors highlighted in Chapter 3, including the history of forced removals and portrayals of Coloured people in the media. Despite the absence of data on community participation in the thesis, the wider literature (cited in section 6.5) has identified questions which need to be addressed for successful community participation in PHC.

The final analysis chapter (Chapter 7 'The end of the project') related the end of the project and analysed the final evaluation meeting. It became apparent that the end of the

project was likely from the moment the managers retreated. Subsequently, Yvette started to retreat and her facilitator/magician acts slowly diminished. When analysing the events around the end of the project, it seems that SAHA conceded that the level of intervention should have been at the management rather than at the facility level. I would agree, although I am not sure if the need for a focus on management in the intervention should be based on the lack of management commitment or power struggles. As the thesis has shown, the failure of an integration project is more complex than just focusing on one role player such as staff or management. It seems to me that although SAHA understood very well the likely barriers to successful integration (see Section 1.1), they perhaps underestimated the inherent power struggles. SAHA was, on their part, also unable to influence the Government and the DoH enough to create supportive management and organisational structures to facilitate change. Chapter 7 highlighted reporting bias in the non-publishing of results which can make piloting seem more successful than it is. Chapter 7 ends with a re-visit to the Paradise Park site in 2006 and concluded that the integration project has led to disintegration of the health-care facility.



8.2 Revisiting the aim of the thesis

This section considers whether the thesis aim has been achieved. It is important to note that my methods and analysis have not been used previously for this type of event (see section 1.2 and 2.2). The anthropological point of view has added value to what is known currently about health-service reform (in this case, facilitated integration of health services) in urban settings. Certainly, the issues raised in Chapter 3 have brought an additional dimension to understanding the actions of actors in the facilitated process. I believe I have also shown that the challenges identified before the start of the pilot project (see section 1.1) can be understood better with an anthropological perspective. The concepts of dominance and resistance, rooted within the framework, provide new and different insights into actors' actions and motivations. Also, the thesis has brought a new understanding to the issue of power struggles, in that such struggles stem not just from a fear of loss of power but they have deeper and different origins and meanings.

What has the anthropological perspective added to help understand staff resistance? From merely seeing staff as being resistant to change, this thesis has brought an understanding to why certain staff members choose certain types of strategies. A similar argument can be made for the responses of the community. Understanding how important the historical roots of a community are in their choice of resistance strategy provides an extra dimension to understand community participation.

8.3 Implications of the findings for other change processes

This section considers the lessons that can be learned from the thesis for other change processes in the health system, whether they are comprehensive or selective. This is particularly important due to the renewed interest in PHC, noted at the start of this chapter. It is also important, as Blaauw et al. (2003) pointed out, because there is a need in health reform to portray the mechanical and economical side of change rather than the human element. Although the research presented in this thesis is over 10 years old, the challenges have not changed whether it is in comprehensive or selective implementation of change. Therefore it is important to explore how the findings of this thesis can contribute to other change processes. The methods used in this thesis could be applied to other similar settings (i.e. an urban public-health facility in a lower-income country) which are functioning well in terms of staff and service delivery but need improvements aiming to reduce duplication of services and health inequity.

I believe the findings are applicable to such settings although each context will have its own management and organisational structures which might bring different challenges. Of course, these challenges need to be addressed but I do not believe that either of these will magically solve staff resistance or management power struggles. Creating one authority and providing solutions to salaries and benefits would clarify who is managing the district health system and provide staff with some job security. However, functional integration at the level of clinics and day hospitals would still need to occur. Change

will always raise insecurities among staff, but the motivations behind strategies of resistance are fixed. Additionally, the analysis suggests that establishing one authority would not necessarily have given the middle managers sufficient power to make the required changes. As such, the findings have implications for similar facilitated processes in other urban public-health facilities. This is where I could make some comments and consider how my findings could be applicable.

This section will focus mainly on staff and management and by extension the facilitator. As highlighted above, the community was never really involved in the integration process and thus it is more difficult to consider how my findings can be applicable to community participation in other change processes.

Informed and context-specific planning

Returning first to the planning stage and the usefulness of the framework, the thesis has shown the importance of considering the historical and social context of the location for an integration project. Planners of future change projects should understand the history of the people they will work with and the historical background of the health system. However, this understanding and analysis of the context should go beyond the health-care system to the wider community. The potential diversity and complexity of local contexts in other settings make it difficult to draw specific conclusions for health-sector reform. This limitation should be remembered while reading my conclusions below.

Effective facilitation

Another implication of my findings around planning a change process concerns the involvement of a facilitator. Yvette was an experienced facilitator and judging from her careful planning and success in achieving the first two stages of rite of passage (i.e. separation and transition), a person with her qualities would be a good choice for any integration project. Clearly, she was experienced and able to focus her knowledge to carefully plan and start the project. Her use of workshops to allow the staff to voice their concerns and thus to feel heard seems to me very good practice. So in terms of the

facilitator, the project should have succeeded. However, the change process never managed to complete the later stages of transition nor incorporate new roles for staff. The analysis showed that Yvette only had control over minor issues such as the choice of site, the workshops, and the initial words of managers. Once the process started, she lacked control over the real actions of managers and staff members. Also, it is unlikely she would have had control over the community, if they had been actively involved.

The thesis findings identified some of the reasons behind these events, so the remaining question is what are the implications for other change processes? The choice of facilitator herself is not in question, so do the actions of the facilitator need exploring i.e. could different actions have led to a successful project? Considering the change process through the three stages of the rite of passage illuminates where the process stalls. It can also be used to consider how the process of change might work successfully. Momentum is needed to take the process through to the last stage. First, I think all the words and the rites of the spiritual state did not really mean anything to staff or management. I have to admit here that my understanding of the health-service integration at the time of the process was limited and somewhat confused. Even with my access to more information, if I (as a researcher) was struggling, how could staff be expected to understand? A better approach would be clarity in the information and statements on what integration entails, where the idea comes from, why it is being done, and what the potential benefit are for the parties involved (i.e. management, staff and the community). None of these aspects were made clear in Yvette's documents, and as the thesis has shown none of these questions about the origins, the reasons for and potential benefit of integration were answered completely. I would recommend that such information would need to be presented in ways and formats that can be understood by the target audiences.

Second, breaking of promises will reduce people's commitment to the change process and ultimately as Bak and Askvik (2005) note in their book on the Administration of

South Africa Project⁴⁵), to undermining trust in institutions. Future change projects should aim to ensure that relevant parties are informed and consulted about important events and decisions in the change process (e.g. the change of service name and appointment of CNPs in the Paradise Park project). To take this one step further, the fear of breaking promises, or despondence and anger as highlighted in section 7.1, should not be a reason to not publish results of a failed project. As highlighted in that section, reporting bias can lead to a distorted view of interventions which will not assist future facilitators.

Commitment and the power of change managers

I now consider the two main implications of the findings around the role of managers for the potential success or failure of other change processes. Using the analytical concepts of dominance and resistance enabled the uncovering of the real motivations behind the managers' lack of commitment. The first main implication is managers believing that a change is not feasible. All key individuals, particularly the relevant managers, have to believe that integration is the right approach to take. They have to see the potential benefits and buy into the idea of change. The thesis has shown that if this is not the case, the process has less chance of succeeding. My thinking is that a belief in the success of a change process could be achieved by involving the managers in planning from the beginning of the process. Such involvement could include learning about former projects and the managers' explanations of the reasons for the projects' successes or failures. Managers also could give input on the choice of site and the formulation of the implementation plan. In Paradise Park, the facilitator took control of the planning stage of the process, which (in my interpretation) hindered the managers from taking ownership of the process.

The second main implication is managers having sufficient power to make the required changes. It occurs to me that this should be a natural part of their job role. Of course there could be a process of consultation and checking with higher management but if the

⁴⁵ The larger project under which data for the thesis were collected.

change is well presented and well evidenced, there seems to be no reason not to give middle management, leading a change process, a degree of power to implement changes necessary.

Informed and involved staff

The next role to be considered is that of staff and the implications the analysis of their role has on other processes. The thesis investigated the different strategies (including resistance) used by people, depending on their position of power. I concluded above that it is important to have clear and continual information about the change process and for a facilitator to keep promises. This is important particularly for staff members who have (or perceive they have) less power. Whether real or perceived, some staff members feared job threats more than other staff members. Such vulnerable staff members need to be heard and given a safe space to voice their concerns. The thesis showed how such vulnerable staff hid behind anonymity or false compliance, which prevented the facilitators and managers from really hearing their views.

Overall, I think using resistance strategies to analyse staff behaviour can allow facilitators and management to better identify and respond to potential problems. These strategies indicate when staff feel insecure or stressed, and appropriate action can therefore be taken. These actions could include, as highlighted above, checking that the process is clear to staff, the potential benefits from change for staff, that information about the change process has been given and promises have been kept.

In the paragraph above on the role of managers, I recommended their active involvement in the planning stage. Similarly, the active involvement of staff would be useful. If staff were able to consider former projects and share their views on why they failed, this might give the staff more impetus to help design a feasible aim and implementation plan for their context. Involvement in planning could also help staff formulate the benefits for each of their positions in the project. Rather than leaving the

power of planning in the hands of one person (the facilitator), active involvement should give staff more ownership of the change process.

Ownership of change

My conclusions above have highlighted the importance of ownership, a concept that has been identified as essential for health-systems strengthening (Reich et al., 2008) and the success of health reform (Scott et al., 2003). The definition of ownership is somewhat unclear in the literature. As Kayizzi-Mugerwa (2003 p.3) notes in his book on governments and the reform of institutions, "the concept of ownership has been used in so many contexts in recent years that its operational usefulness has diminished considerably as a result". Ownership needs to be clearly defined and operationalised to be useful. I believe this can be achieved for reform in health institutions by clearly defining the concept and its perimeters. From the discussion of the thesis findings, I have adapted Kayizzi-Mugerwa's definition for ownership as "the internalisation of the reforms to such an extent that the person(s) involved are prepared to defend them." I favour this definition as it involves all the elements highlighted in the discussion above. For instance, in order for CHC staff to justify a pilot project of integration in their centre to other stakeholders in the district, the staff would need to be very clear on what integration entails and its potential benefits. Benefit is an important element of internalising the proposed reform. Bahamon et al. (2006) note that both implementers and beneficiaries have to recognise something that would benefit them in a new way of working. The thesis showed how this applies to both staff and management, and potentially the community.

Internalisation also means that the concept of integration has to be owned at the local level. Cassels (1995) points out that ownership is the opposite of reforms that are developed by foreign consultants. This view is supported by Franco et al. (2002), who argue that lack of local ownership will hamper commitment to the process by staff. Although the process described in the thesis was not led by a foreign facilitator, it was based on foreign concepts designed by WHO. Of course, considering the community's

viewpoint of outsiders, it might well have been. Reforms based on a foreign concept need to be adapted at a local level for people to become involved actively.

The persons involved in the definition of ownership should include staff, management, community and facilitators. As Drayton (2003 p.591) notes, “cross-sectoral success stems from the ownership that develops when various stakeholders participate in developing action and policy”. Drayton continues by highlighting that fragmentation between those who make the policy and those who implement is a barrier to successful implementation. Involving managers, staff and community in the planning of change processes can help overcome this barrier. This suggestion reinforces my conclusion that management and staff have to be involved from the beginning of the planning process. Although lack of data prevented the role of community from being analysed fully, similarly, they need to be involved.

The manner in which people are involved is highlighted by Bracht et al. (1990 p.201). Their article on effective community participation identifies the need for people to “shape their own directions and emerge with the necessary self-help skills and resources to manage continued and/or new efforts”. For me, this quote reinforces two conclusions. First, staff, management and community need to be involved in planning of change processes. Second, the implementers of change need control over resources and power over decision making. For example, managers should have the ability and authority to manage their staff during reforms (Soeters and Griffiths, 2003).

8.4 Conclusion

In conclusion, to allow change processes to succeed all parties involved need to have ownership of the process. Active involvement of (particularly) staff and management in the planning process will help ensure that the process maintains momentum. Involved parties need to understand the change process and the potential benefits of reaching its goal. Throughout the process, all role players (including the community) need to be provided with continual and clearly formulated information. Finally, those parties charged with managing the change need appropriate power and capacity to carry out this role. Failing health-sector reforms undermine trust in public institutions. The analysis, successful planning and implementation of reform of PHC requires considering different points of view. This includes the anthropological viewpoint, which has been provided in the thesis.



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