Communities in Transition:
Representation and Accountability

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The in-depth health situation analysis conducted in the Bushbuckridge region of the eastern Transvaal lowveld reveals that community representation in health policy, and accountability of the health services to 'the community' are not easily arrived at. The complex social composition of the area, the large number of organisations and structures, the duplication of health services as a result of the homeland system, and the current political uncertainties, all present obstacles to the formation of representative structures to which a future health service could be accountable.

Who is the 'Community'?

People often talk about the 'community' as if it were a homogeneous entity which speaks with one voice. Instead there are a variety of social situations, each of which generates its own needs and wants.

A major cause of this division is the homeland system. In the Bushbuckridge area many people have been resettled, pushed together with people from different areas and backgrounds, in the interests of reinforcing ethnic identities and the homeland system. Tsonga speaking Shangaans were pushed into the Mhala district of Gazankulu, and Pedi speaking Sothos were pushed into the Mapulaneng district of Lebowa. Although the border between the two districts is arbitrary and is often marked by a road or railway line, people have only had real access to the health services in their 'homeland', even if those in the other 'homelands' were geographically more accessible. Those within the homeland system have also mobilised around their ethnic identities in disputes over resource allocation.

Other sources of social division and stratification include the gap between literate and illiterate, employed and unemployed, migrant and permanent resident. In some villages, 70% of the men are migrant workers.

Mozambican Refugees

This is further complicated by the presence of Mozambican refugees living in Mhala, who speak a version of Tsonga. Those officially registered with the

Difficulty of access to limited resources between groups causes tension.
Photo: Tsheko Kabasia

Gazankulu authorities number around 30 000, but relief organisations estimate at least double that number in Mhala alone (out of a total population of 211 000). Having arrived, the refugees are confined to Mhala, under threat of immediate deportation back to Mozambique if found elsewhere.

When refugees first arrived in large numbers in 1984-5 they were welcomed by the residents of Mhala because they share a common culture and language. However, many now live in physically distinct villages, and qualify for relief aid which is not available to the local population. At the same time, the refugees place further strain on already overstretched health and education facilities and the key resources of land, water and employment opportunities. In times of widespread scarcity, such as the drought of 1993, these issues of resource allocation cause tensions.

The deepening of divisions between three major groupings (Shangaan, Sotho, refugees), each of which is in turn stratified, makes it more difficult for people to organise themselves, and for the health services to provide equal access to all. This is compounded by the lack of clear authority structures and channels of accountability, both in public life and in the home.

Structures of Authority

The result has been the development of similar parallel structures, each designed to serve the needs of each of the major groupings described, none able to address the needs of 'the community' as a whole. The four major groupings claiming authority in public life are the tribal authorities, the civics, the homeland authorities and political parties.

Each tribal authority has a chief who is represented by indunas at the village level. Broadly speaking, the function of the chief and his indunas is to attend to the welfare of their people, particularly by resolving minor local level disputes and by representing the people to higher authorities. They are paid by their homeland government. In Mhala they tend to chair the village development committees, initiated by the Gazankulu government, which have met with varying degrees of success. Whether due to a lack of resources and/ or lack of control over resources, chiefs and indunas are sometimes reluctant or unable to tackle health issues, for instance, by assisting their communities to fund-raise.

Alternative Structures of Accountability

A major challenge to the tribal structures has been the emergence of the civic associations in the course of the last ten years. While in some areas they are trying to work in co-operation with the chiefs and indunas, their very nature as local level structures inevitably questions the authority of traditional and government structures. This is further complicated by the fact that civics seek to be broadly representative of the people but in practice tend to be ANC aligned, or are perceived as such, thus excluding some sectors of the population, particularly the older generations.

At a district and regional level, there are no well established civic structures. Support for both the two political parties active in the area (the ANC and Ximoko Xa Rexaka, an explicitly Tsonga party closely tied to bantustan structures) is patchy across the whole area, with a relatively low level of regional cohesion.

Health Related Structures

The Mhala Health Action Group and the Mapulaneng Development Committee aim to ensure that the health needs of the people of Mhala and Mapulaneng reach the attention of local health services, government and independent donors. Neither structure has a well organised constituency or can claim to be broadly

The stratification of 'community' - a complex mixture of power, ideology, and culture, all working together. *Photo: unknown*

representative. It is clear, there are no broad structures which can truly claim to represent the interests of the Bushbuckridge community. This situation is symptomatic of a general lack of democratic structures and organisations and a lack of accountability at local, regional and national level.

However, in this vacuum of public authority, churches and non-government organisations can play an important role.

Religious Groups

There are a large number of churches in the area, with both small and large followings. They include the Nazarene Revival Crusade and the Zion Christian Church (ZCC).

The welfare function of the churches needs to be documented, but many examples exist, including the use of the church buildings for non-church activities such as creches, and the involvement of the Catholic Church in relief operations to the refugees.

The University of Witwatersrand Rural Intervention

The Bushbuckridge area is unusual in having three University of Witwatersrand related rural projects based there. These include the Health Services Development Unit, the Wits Rural Facility, and the Community Rehabilitation Worker Training Programme.

The Community Rehabilitation Worker Training Programme draws students primarily from the area. A large component of the training occurs in the students' own villages, where they are expected to return on completion of training.

Wits Rural Facility is an interdisciplinary unit involved in teaching, research and outreach. It aims to influence the content of university curricula, and to engage in research of benefit to the immediate and wider communities.

The Health Services Development Unit is the oldest Wits University rural project, established in the early 1980s. It currently engages in education and training, including primary health care nurses, a village development programme, a sexual health programme and health systems development.

The most important of these, in terms of developing community representation and health service accountability is the District Health Initiative, arising out of the health systems development programme. At a local level this has involved the initiation of a number of village level health committees. More broadly, this initiative is working on 'breaking out' of the present homeland framework, and has sought support from sub-regional and national health and technical authorities. It is worth noting that even such forward looking initiatives are hampered by the fact that the government's proposed development regions differ from those of the ANC. The lack of clarity on future government structures will obviously obstruct the formation of accountable health services for some time to come.

A recent development which seeks to address this issue has been the North Eastern Transvaal Health Worker and Community Education Project (NETHWORC). Set up in late 1991, NETHWORC is working towards constructive partnership between the Bushbuchridge community, the local health services based at Tintswalo and Mapulaneng and the local University of the Witwatersrand projects mentioned above. The project has brought together traditional and non-traditional structures, governmental and non-governmental organisations, and people both with and without formal education. This process of increasing dialogue is slow but effective, and is being extended to other health related sectors, in particular water and education.

In addition a variety of small scale initiatives exist in response to the needs of specific interest groups such as women, the unemployed, and the disabled.

A path to more effective accountability

To conclude, broad community representation and meaningful health service accountability are difficult to attain when major groupings are played off against one another for political purposes, a process which has been institutionalised in the tangled web of South Africa's bureaucratic structures. It is also difficult when nobody can say exactly who has authority and power at local level, or where authority resides with different structures within a relatively small geographical area.

Although there are numerous non-formal organisations, such as the churches, many do not have health as a prime concern, nor are representation and accountability seen as important issues. Non-government organisations working in health, faced with ensuring the survival of their own projects, the obstinacy of existing bureaucratic structures and the pressure to respond to people's needs, may be pushed into providing alternative although unsustainable delivery programmes which only have a very localised impact, and which do little to engender representative and accountable health services.

The situation as described in the Bushbuckridge area is no doubt reflected in many other parts of South Africa as well. However, those difficulties are also opportunities, particularly if the non-government sector is in a position to stimulate activity. Both the district health initiative and NETHWORC have taken the above problems as their starting point and key motivation rather than as an unplanned-for hindrance. At a time when political structures are in question it is possible to bring together people around issues of common concern, people who in more settled times might not have reason to speak to one another. In these times, the message that "health knows no boundaries" has a chance of being heard.

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