Health Committees in South Africa: The Influence of Power on Invited Participation in Policy and Practice

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Declaration

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Abstract

This study explores how the presence of multiple forms of power impact health committee participation in South Africa's Western Cape Province in policy and practice. A qualitative case study with a rural and an urban committee is used to explore the research question.

The study's conceptual framework views health committees as invited spaces where citizens are invited to participate, in contrast to closed spaces without citizen involvement and claimed spaces where citizens claim participation. The study considers the impact of three different forms of power, namely: a) countervailing power, an external form of power, which neutralises power differentials between officials and community members; b) constraining power, which limits influence; and c) enabling power, which promotes agency.

Three models for invited participation are identified: 1) Appointed participation, envisioned in the Western Cape Health Facility Boards and Committees Act (2016); 2) An organisational model, preferred by the health committees; and 3) An election model, considered in policy documents. The study found that the health committee Act provides health committees with countervailing power in the form of a mandate. However, the content of the Act ensures that the Health Department controls who participates through ministerial appointments and limits health committees' influence through stipulating narrow roles. The practiced organisational model generates countervailing power through a claim to represent communities, but this claim is challenged by weak community links and accountability mechanisms and the fact that only organised sections are represented. Furthermore, the study demonstrates that absence of countervailing power and presence of constraining forms of power limit health committees' influence, though they also draw on enabling forms of power. In addition, the study demonstrates that when citizens have limited influence in invited spaces, they consider creating claimed spaces. Finally, the study argues that a model with elected community representatives may provide stronger countervailing power as elections may enable health committee representatives to claim to represent the entire community.

The thesis concludes that invited participation may generate sufficient countervailing power when it is legislated and based on a human rights approach, which positions committees as claim-makers and the state as duty-bearer. Furthermore, it concludes that both countervailing power and enabling power is necessary for effective substantive participation.

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List of acronyms and abbreviations

AGM ..... Annual General Meeting
AIDS ..... Acquired Immune Deficiency Syndrome
ANC ..... African National Congress
ARV ..... Antiretroviral
COMCO ..... Community Civic Organisation
CMHF ..... Cape Metro Healthcare Forum
CESCR ..... Committee on Economic Social and Cultural Rights
COSATU……Congress of South African Trade Unions
DHC ..... District Health Council
DoH ..... Department of Health
EQUINET……....Regional Network on Equity in Health in East and Southern Africa
HIV..... Human Immunodeficiency Virus
ICESCR..... International Covenant on Economic Social and Cultural Rights
IDS ..... Institute for Development Studies
IDRC ..... International Development Research Cooperation
LGBT ..... Lesbian, Gay, Bisexual and Transgender
LN ..... Learning Network
MEC ..... Member of Executive Council
MSAT..... Municipal Sectorial Action Team
NHA ..... National Health Act
NHI..... National Health Insurance
OAU ..... Organisation of African Unity
PHC..... Primary Health Care
PHM..... People's Health Movement
SANCO ..... South African Civic Organisation
SACP..... South African Communist Party
SANPAD…… South Africa-Netherlands Research Programme on Alternatives in Development

TAC..... Treatment Action Campaign

TB ..... Tuberculosis

UN..... United Nation

WHO ..... World Health Organization

ZAR..... South African Rands

1 Introduction

1.1 Outlining the problem and research justification

The topic for this thesis is institutionalised, invited health committee participation in South Africa, in policy and practice. It explores how different forms of power impact on health committees in terms of their ability to provide community input and influence in health governance. Linked to this it considers whether invited participation is a viable form of engagement between citizens and the state.

Invited spaces refer to spaces where citizens are invited to engage with officials. The thesis focuses on exploring how power impacts on health committees' influence in Primary Health Care[1] (PHC) through a multiple case study with an urban and a rural health committee in the Western Cape Province of South Africa. Health committees are legalised participatory structures supposed to exist at all primary health care clinics and centres in South Africa and be composed of community members, local government councillors and facility managers. These representative structures are intended to ensure that health services meet communities' needs. This introduction begins with outlining the problem this thesis addresses; next, I present the research questions; and lastly, I provide an overview of chapters**.**

The study uses the Institute of Development Studies' framework of closed, invited and claimed[2] spaces (Powercube, 2011)[3] to categorise different forms of participation. Based on this framework, the study conceptualises health committees as invited spaces, understood as spaces where authorities invite citizens[4] to participate. An invited space is conceptualised in

[1] I distinguish between primary health care when I refer to primary health care services and Primary Health Care or PHC when I refer to this particular approach to health.

[2] Sometimes this space is also referred to as 'invented' or 'created'. The preferred term in this thesis is 'claimed' space.

[3] The Powercube is referenced differently by different authors. Gaventa (2006) prefers 'power cube', while the Institute for Development Studies uses both 'Power Cube and Powercube (in the title). I use the Powercube in alignment with the title and to indicate that I am referring to a specific analytic tool.

[4] When I use the term 'citizen' in this thesis it refers to a generic sense of citizens as people having a say in relation to government services, irrespective of whether they qualify for national identity or not, rather than people who hold national citizenship. The fact that claiming rights for people who do not have national citizenship is a complex issue is beyond the scope of this thesis.

contrast to (i) traditional closed spaces, where there is no or limited participation by citizens; and (ii) claimed spaces, where citizens claim participation for instance through social movements or protests.

Institutionalised, legislated participation is an important feature of post-apartheid South Africa's constitutional and legislative framework. Health committees at primary health care level are examples of participatory structures at institutional level, but participatory structures and processes exist in many areas. Examples include school governing bodies, community policing forums and participatory processes in environmental impact assessment and municipal budgeting. Institutionalised community participation in the health sector has existed since the *National Health Act, No 61 of 2003* (2004) (henceforth also referred to as the *National Health Act* or the NHA) made provision for health committees at primary health care facilities, though it requires provincial legislation to give effect to the NHA's intention. In the Western Cape Province, where this study was conducted, provincial legislation was passed in 2016 but, although promulgated in 2017, it had yet to be implemented by the time this research was concluded in November 2018.

The NHA provides minimal guidance on health committees beyond outlining their composition and leaves it to provincial legislation to provide descriptions of roles and processes for establishing committees. Thus, the existing structures can be considered invited spaces, but they are invited spaces with an unclear mandate.

At the same time as participatory structures have been established, South Africa has seen a surge in social movements and protest movements (sometimes associated with violence). This has occurred both outside and within the health sector. In health, the Treatment Action Campaign (TAC) is one example of a social movement that uses means other than participatory engagement, such as protest and litigation, to engage with and make claims on the state. Thus, there are two distinct forms of public engagement between citizens and the state: a participatory engagement and a mobilisation/protest engagement, or invited and participation, respectively, in the post-apartheid era.

There is contradictory evidence on whether invited participation works, both internationally and in South Africa, inside and outside the health sector. The question to a large extent depends on how this is assessed. For instance, some studies measure 'outcome' in terms of

improvements in health service delivery such as coverage and immunisation rates, though in many cases the causal links presented are weak (Loewenson, 2000; McCoy, Hall & Ridge, 2012). Some scholars argue that the potential of invited participation depends on the design of these spaces. They also emphasise the importance of the conditions under which participation takes place (Cornwall and Coelho, 2007). Other scholars, focusing to a large extent on participation in local governance in South Africa, view the proliferation of protest movements as evidence that citizens have disengaged from the state and rejected invited participation (Sinwell, 2015; Thompson, 2007; Thompson and Tapscott, 2010). The literature hence points to the importance of considering both the possibilities inherent in, and the constraints of, the invited space.

This study reframes the question of whether invited participation works to a question of when and how and which forms of invited participation may work and under what conditions. It does so within the broader South African context of experiences with invited and claimed spaces. The study situates community participation in health within a participatory democracy, a human rights and a Primary Health Care approach to participation. Together these approaches are used to define participation in the health system as influence in decision-making at various levels of the health system in priority setting, planning, implementation and accountability – in short in health governance. As some scholars have argued, this inevitably means that power dynamics are crucial in understanding how participation is practised (Fung and Wright, 2003a; George et al., 2015b; McCoy, Hall & Ridge, 2012). The fact that participation takes place between people in unequal power positions and is about decision-making inevitably means that power is a central factor. Despite power being identified as an important determinant for participation, there has been limited attention to the way that power operates in participatory spaces, in particular in the health sector. This study aims to address this gap. It uses power as a lens through which participation can be understood and examines how forms of power impact on participation. It is based on an assumption that the operation of power shapes the potential of participation.

The question of how power impacts on participation is firstly explored in relation to the *Western Cape Health Facility Boards and Committees Act, 2016* (2016) (henceforth also

referred to as the Act or the Western Cape Act).[5] Second, it is explored in relation to current models of establishing health committees, where persons meant to represent communities are chosen from community organisations. Thirdly, I explore decision-making and power in practised health committee participation. Lastly, I consider how participants' experience of the Act and of their practised participation impacts on their decisions with regards to participating in invited participation or in new claimed participatory structures.

1.2 Research questions

Based on the research justification above, the research question this thesis addresses is therefore:

1. How do different forms of power impact on South African health committees in terms of their ability to provide community input and influence in health governance?

To answer this, the following sub-questions will be addressed:

a. How are forms of power expressed in the *Western Cape Health Facility Boards and Committee Act, 2016* (2016) and how do these expressions of power delineate the potential for substantive participation? How is the invited space constituted both by the content of the Act and the consultative process preceding the Act? (links to Chapter 5);

b. How does the way health committees are formed currently impact on their legitimacy and their power? (links to Chapter 6);

c. How is participation practised and how do different forms of power impact on how much influence participants have? (links to Chapter 7);

[5] Health facility boards are participatory structures at hospital level. Health committees are participatory structures at primary health care (clinic) level.

d. How do health committees' understanding of and experience with policy, practice of participation and power impact on their engagement with different forms of participation and choices made with regards to spaces of participation? (links to Chapter 8).

e. Is invited participation a viable form of engagement between citizens and the state and its institutions? (links to Chapter 9).

1.3 Chapter outline

In July 2016 the Western Cape Provincial Government approved legislation to formalise health committees. This took place 12 years after the *National Health Act (*2004) obliged provincial governments to legislate participation on health committees. Eighteen months later, in December 2017, implementation of the Act began with nominations of health committee members in the province.

The study presented in this thesis began with the adoption of the Act and active fieldwork ended 1 1/2 years later in January 2018, though I continued to keep in touch with the committees and followed the nomination process and implementation of the Act.

The thesis begins with a chapter that reviews the literature related to participation and conceptual understandings of participation. This chapter, Chapter 2, consists of three sub-sections. First, I outline three different approaches to participation: a democratic theory approach; a human rights approach; and a Primary Health Care approach. Drawing on these three approaches, I argue that health committee participation could be viewed as influence in decision-making on priorities, planning and implementation in Primary Health Care – in short in health governance. The chapter presents the framework of closed, invited and claimed spaces, and suggests that health committees in South Africa can be viewed as a form of invited participatory structures at primary health care level.

Second, I situate participation in post-apartheid South Africa and outline legislation for health committees. Lastly, the chapter considers the evidence for participation both inside and outside health, and both internationally and as it relates to South Africa.

The third chapter presents a literature review related to power and conceptual understandings of power. It starts with arguing that power in participation is an under-researched but important dimension. The first section presents Steven Lukes's (1974) three faces or power and the International Development Institute's *Powercube* (2011), with a specific focus on three different forms of power: visible, hidden and invisible forms of power. It proceeds with presenting Mark Haugaard's (2003) understanding of power, which can be viewed as a closer exploration of Lukes's and the *Powercube*'s third face/invisible form of power. Haugaard calls this internalised power. Haugaard's theoretical framework resonates with many philosophers' understandings of how power can be embedded in structures and cultures, and therefore be 'invisible'. Furthermore, Haugaard – again in agreement with other theorists – presents an understanding of how agency is still possible in cases where power is internalised.

James Scott's (1990) theory on hidden and public transcript is presented next. Scott's understanding of power is a contrasting view of power to Haugaard's. Scott disagrees with the notion that beliefs are internalised. Instead, he suggests that two transcripts are created: a public transcript, which on the surface looks like internalised beliefs, and a hidden transcript, which is a form of resistance, a discourse talking against the public transcript. The hidden transcript exists in social spaces to which the powerful do not have access.

Following Scott, the review presents Fung and Wright's (2003a) concept of countervailing power, defined as a form of power necessary for participation between people in unequal power positions. The authors propose that participation without countervailing power cannot succeed and outline potential sources of this form of power.

Lastly, I outline VeneKlasen and Miller's (2007) view of power, which focuses on forms of power which enable agency. The authors take the *Powercube* as a starting point, but add three concepts – 'power with', 'power to' and 'power within' that enable – rather than constrain – agency.

Chapter 4, the methodology chapter, describes reasons for selecting of a multiple case study to explore participation and power. It presents the qualitative methods applied. The methodology chapter also outlines the data-analysis approach, which combines an inductive (grounded theory-inspired) data-analysis approach, with deductive approaches based on the

theories and concepts described in the previous chapter on power. The methodology chapter describes how rigour was enhanced through prolonged engagement, triangulation and continuous member checking. Reflexivity is discussed, including describing challenges that arose and ways of dealing with them. Methodological challenges such as the impact the research had on the object of the research, health committee participation, is discussed and I outline attempts at mitigating these challenges. The chapter ends with a description of the two health committees that were part of the case study and the socio-economic contexts of the study sites.

There are four findings and analysis chapters, Chapters 5 to 8. The first explores the creation of the invited space that is being constituted in the Western Cape with the adoption of legislation on health committees. The chapter argues that the invited space is shaped not only by the content of the new legislation, but also through the consultation process leading up to the promulgation of the Act. It analyses the legislation and how health committee members analysed and understood the content of the Act, and how they experienced the consultation process that preceded the adoption of the Act.

Chapter 6 is concerned with how health committees are established and claim legitimacy. It describes how the two health committees were formed either through organisational 'elections' or through a group of individuals forming the health committee. It considers what these models and processes mean for claims to representivity and legitimacy. The chapter ends with considering what the different formation processes means for how much countervailing power participants have.

Chapter 7 analyses the practice of participation, using the democratic theory, human rights and PHC approaches outlined in Chapter 2. This is proceeded by a section that identifies forms of power that limit agency and influence, followed by an account of enabling forms of power which promote agency.

The last findings and analysis chapter, Chapter 8, turns its attention to how health committees navigated the implementation of the Act and made choices between invited and independent claimed spaces. It does so in the context of how the Act was understood and how the creation of the invited space was experienced (Chapter 5) and in the context of their experience with practised participation (Chapters 6 and 7).

Chapter 9, the discussion, considers if and under which conditions invited participation is a possibility allowing for community input and influence. After summarising the findings and analysis and discussing the implications of these, the chapter reflects on implications for the conceptual frameworks for participation and power, respectively. The discussion also outlines policy implications and practical lessons for those engaged in participation.

The last chapter of the thesis (Chapter 10) concludes by providing a summary of the main arguments.

The thesis indicates that quotes are verbatim by using double quotation marks (“”). Single quotations marks (‘’) are used when a quote is not verbatim or when words or concepts are repeated and cannot be attributed to a single person. The reference system used is Harvard-UCT.

2 Participation: literature review and theoretical concepts

2.1 Introduction

The first section of this chapter provides a conceptual understanding of community participation in the health system through three different approaches: a democratic theory approach, a human rights approach and a Primary Health Care approach. The second section outlines the role of participation in post-apartheid South Africa. The section describes the legislation that gives effect to health committees at national level and in the Western Cape. The third section provides an overview of global and South African experiences with participation in and outside the health system. It begins by considering conceptual understandings of community participation in health. It then presents models for measuring influence in decision-making and research concerned with assessing health committees' influence. This is followed by a description of factors influencing health committee participation. I then turn to debates on the question of whether invited spaces are effective and, if so, under what conditions, drawing on both international and South African experiences inside and outside the health sector.

Drawing on the contradictory evidence on how well participation works, I suggest that rather than framing an analysis of participation as a question of whether participation works or not (as is often the case), this thesis approaches the question from a different angle. It suggests that a closer look at what happens in and 'around' the participatory space is useful to explore the possibility of invited participation. In particular, I suggest that power is an important factor in understanding the potential for effective invited participation.

2.2 Three approaches to participation

2.2.1 Participatory democracy and participation

Participatory democracy developed as an alternative to pure representative democracy. Some theorists see it as a response to voter apathy, a trust deficit between citizens and their representatives, and people's disengagement and disillusionment with political institutions in traditional liberal representative democracies (Calland, 1999; Hilmer, 2010; Avritzer, 2012; Pateman, 2012). This led theorists such as Pateman to suggest new forms of engagement

between citizens and the state, where citizens take on a more direct and active role compared to the periodic voting that characterises representative democracy (Pateman, 1970) and become involved in self-governance (Hilmer, 2010).

Pateman contrasts participatory democracy with elite theories of democracy (such as those of Schumpeter and Dahl), which, according to Pateman, view participation as having a minimal role in democracy, a role that is limited to periodic elections. In contrast, she draws on theorists such as Rousseau, Mills and Cole to suggest that participation has long roots in democratic theory and that her idea of a participatory society was first envisioned by these theorists. One of the main ideas in Pateman's work is that participation should be expanded to many areas of public life. Democratisation of the workplace is a particular focus of her work. She claims that through participation in 'lower' level structures such as local government and the workplace, people learn to participate through the act of participating. An important function of participatory democracy, according to Pateman, is its integrative function, which means that individuals accept collective decisions more easily in participatory systems because they have been part of the process.

Another important component in Pateman's theory relates to control. Pateman argues that participants must feel a degree of control and that they can have real influence. Where much of the literature on participation talks about influence in participation, Pateman talks about a form of power where protagonists have an equal say. Pateman makes a distinction between influence and power, saying that when you have influence, someone else may still be able to make decisions, but if you have power you have an equal say in decision-making. Thus, she defines the concept of participation in participatory theory as follows: "Again, in the participatory theory 'participation' refers to (equal) participation in the making of decisions" (Pateman, 1970:43). Pateman's theory emphasises the importance of inclusivity and argues that steps should be taken to ensure that there are no barriers to participation. In a more recent article Pateman (2012) argues that participatory democracy is about democratising social and political life through providing "opportunities for individuals to participate in decision-making in their everyday lives as well as in the wider political system. It is about democratizing democracy" (Pateman, 2012:10).

Democratic theorists view influence as central and distinguish between full and partial participation. According to Pateman, partial participation is "a process in which two or more parties influence each other in the making of decisions but the final power to decide rests with one party only" (Pateman, 1970:70). In contrast, full participation in Pateman's understanding entails a process where individuals have equal decision-making power. Another political scholar with an interest in participatory democracy and deliberative democracy is Mansbridge (1980), who draws a distinction between adversary and unitary democracy. The unitary form - which participatory forms can be said to be part of - assumes that citizens have a common interest (rather than conflicting interests) and therefore collaborate.

The relationship between representation and participation is central in debates on participatory democracy. Importantly, proponents of participatory democracy such as Barber (1984) acknowledge that a representative system where citizens delegate power is necessary in complex societies. Pateman also acknowledges the importance of representative institutions at national level but argues that the existence of such institutions is not sufficient for democracy. Thus, participatory democracy is not necessarily in opposition to representative democracy. Rather, it is about maintaining the balance between representation and participation. As Held notes:

> … within the history of clash of positions lies the struggle to determine whether democracy will mean some kind of popular power (a form of life in which citizens are engaged in *self*-government and *self*-regulation) or an aid of decision-making (a means to legitimate the decisions of those voted into power) (Held, 2006:3).

In relation to the balance between representation and participation, Carpentier (2011) makes a useful distinction between maximalist and minimalist democratic models. Decision-making remains centralist and participation minimal in the minimalist version, whereas the opposite is true in the maximalist versions (Carpentier, 2011). Thus, representative democracy and participatory democracy can easily coexist. Some view participation as a way of strengthening representative democracy, such as Calland, who argues that participation can lend legitimacy to representative dispensations (Calland, 1999).

Participatory theory has to some degree been replaced with deliberative democratic theory in terms of interest amongst theorists since the 1990s. Though the terms 'participatory democracy' and 'deliberative democracy' are sometimes used interchangeably, most theorists argue for viewing them as distinct forms, as noted by Hilmer (2010) and Pateman (2012). The main difference is that deliberative democracy is characterised by the mode of engagement. In deliberative democracy, citizens or participants deliberate over issues and reach decisions through reasoning, thus making decisions that are 'reasonable'. Deliberation can take place in participatory democracy but need not. Participatory democracy views the extension of democratic practice and citizen participation to new sectors such as the workplace as important. This is not necessarily the case for deliberative democracy. Moreover, Hilmer (2012) argues that participatory democracy is characterised by shifting power away from the macro level of the state to micro levels, to local levels. According to Hilmer, this shift to micro levels does not necessarily take place in deliberative democracy. Another difference between participatory and deliberative democratic theories is that participatory theorists often argue that participants learn through the very act of participation, whereas deliberative democrats favour facilitated discussions. Thus, participatory democracy can take a deliberative form and deliberative democracy can be participatory.

There is a plethora of definitions of both participatory democracy and participation and, as noted by Pateman, the term 'participation' is used to include a wide range of disparate activities (Pateman, 2012). Moreover, there has been a proliferation of forms of participatory engagement, and terms such as democratic governance, participatory governance, co-governance have emerged. While there are differences between them, together with participatory democracy and deliberative democracy, they are all characterised by involving citizens more directly in decisions that affect them. Many of these terms are used interchangeably. Pateman, for instance, argues that participatory governance is the same as co-governance.

It is beyond the scope of this literature review to debate the differences between the many concepts of participatory democracy and deliberative democracy. Henceforth, the concept participation or participatory forms of democracy will be used as generic terms to characterise citizens' direct involvement in decision-making with officials. South African health committees will be characterised as participatory structures based on the fact that they

have a legal mandate for participation and as such can be considered as structures where lay-people/citizens are invited to engage with officials.

In addition organised participation, modern societies have seen a proliferation of different forms of informal participation. This has occurred through social movements, civil society and interest groups engaging with the state in different ways (Carpentier 2011:169). The Institute for Development Studies' framework of closed spaces, invited spaces and claimed spaces (Powercube, 2011) reflects this by expanding the notion of participation to considers citizens' informal engagement as a form of participation in contrast with formal forms of participation. Closed spaces refer to spaces where only a select few participate, such as in political institutions. Invited spaces are spaces where authorities or institutions invite the public to participate. The third space is that of the claimed, or self-created space. These forms of participatory spaces are created by actors such as social movements, community associations or civil society organisations. The framework of closed, invited and claimed spaces is particularly useful for the following reasons:
1) the framework is useful because it is evident that South African health committees can be considered invited spaces: they are legally constituted entities in which health authorities invite people to participate;
2) these invited participatory structures co-exist with forms of participation such as social movements and protests.

Following this conceptualisation of invited spaces, there has been a plethora of terms for invited participatory spaces such as: 'conquered', 'instigated', 'initiated', 'formal by invitation', 'formal by right', 'created by institutions', 'created by organisation' and 'transitory collective direct action' (Powercube, 2011). This indicates that invited spaces can take many different forms and have many different characteristics. Understanding the particulars of an invited space is important. When talking about health committee participation, this thesis is concerned with a form of invited, institutionalised, formal, collaborative engagement between citizens/lay-people and officials in an invited space. It views this in contrast with a claimed space.

Participatory forms of democracy are argued to have many benefits. The claimed benefits can be categorised as either democratic, instrumentalist or psychological. The democratic benefits are often framed as 'deepening democracy' or democratising democracy (Fung and Wright,

2003a; Cornwall and Coelho, 2007). As a consequence, they may restore or build trust in political institutions (Head, 2007). Participation is believed to create a more active, informed and astute citizenry (Hilmer, 2010). Furthermore, Hilmer notes that the expansion of democratic participation into traditionally non-participatory sectors of society tends to break the monopoly of state power and engender a more equitable and humane society. The claim that participatory democracy can serve social justice goals is shared by Head, who argues that participation enhances equity goals, because it involves and includes participants whose views are often excluded in more traditional decision-making forums (Head, 2007). Hilmer similarly argues that participatory democracy empowers traditionally unrepresented and excluded members of society. This is, according to participatory theorists, in contrast with liberal representative democracy, where the poorer citizens often are excluded or the voices of poor members of society are often not heard. Participatory democracy is seen as addressing this through the principle of inclusivity (Hilmer, 2010). It is seen to consolidate democratic beliefs, practices and principles, and thus strengthen a democratic state by rendering it more legitimate.

> The evidence suggests, then, that participatory democracy does indeed help to put a society on the path towards a more equitable and humane future. And it is the application of the theory of participatory democracy which enables us to understand how this process operates (Hilmer, 2010:62).

Within a more instrumentalist thinking, one of the main benefits cited by proponents of participation is that it leads to better informed decision-making (e.g. Head, 2007) and implementation, partly because it relies on local or citizen knowledge (Creighton, 2005). Creighton also claims that participation improves the legitimacy of decisions, which leads to improved service delivery (Creighton, 2005). Heed concurs: “At the local level, there is an increasing appreciation of the benefit of involving local citizens in identifying problems and contributing to the solutions” (2007:443). Participatory democracy is considered to have an impact on good governance. Advocates for participatory democracy emphasise that the educative principle has positive psychological effects as people feel empowered through the process, and that participatory spaces become spaces where people are educated as democratic citizens.

Debates about participatory forms of engagement also focus on potential barriers to participation. Some question the assumption that citizens have the skills to become involved in participation. Calland (1999) claims that only those already empowered are able to participate. Similarly, Hilmer (2010) contends that citizens cannot be expected to acquire the highly specialised knowledge, including technical knowledge, to govern a complex modern administrative state. Others point to how participatory spaces work for different people. The way the spaces operate may validate some actors and silence others (Fung & Wright, 2003c). In a similar vein, Fung and Wright warn that more powerful participants may choose other avenues if their interests and views do not prevail in the deliberative forums. The same could be said for participatory forums.

While theorists list many potential benefits, they also caution that participation can have negative consequences. For instance, there is a risk that participatory structures are captured by elites (Head, 2007). It can be used to shift 'blame' for decisions and their outcomes away from government. This raises the important question of what interests the state and its institutions may have in engaging in participation. Another contentious issue raised by amongst others Pateman is the risk that participation becomes pseudo-participation and that if participants do not have sufficient power to influence decisions, they may become disillusioned with the process. It is also argued that participation may at the same time lessen support for protest movements (Head, 2007).

Even though political scientists and theorists have turned their interests to deliberative democracy, it is widely acknowledged that participation or participatory structures have proliferated (Hilmer, 2010). This can also be said to be true for South Africa, as I will demonstrate in a later section. As noted by Scott (2009:31): "Today public participation is increasingly considered standard practice and is regarded as an essential characteristic of and condition for a successful modern democracy".

2.2.2 A human rights approach to participation in health

This section explores participation within a human rights framework - as a right linked to the right to health. The right to health became enforceable as an internationally recognised right with the adoption of the *International Covenant on Economic, Social and Cultural Rights*

(ICESCR) (UN General Assembly, 1976). The covenant recognises the right to health as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental wellbeing" (UN General Assembly, 1976:art.12.1). In *General Comment 14* (UN Committee on Economic, Social and Cultural Rights, 2000), which is an expert interpretation of the right to health, participation features as a central component to achieve the right to health. Importantly, the *General Comment 14* argues that participation in health systems should entail 'decision-making' and should occur at local (community), national and international levels (UN Committee on Economic, Social and Cultural Rights, 2000). Furthermore, this should entail involvement in decision-making with regards to priority-setting, planning and implementation of health services. *General Comment 14* specifies that participation also involves being part of political decisions related to health at community and national levels including involvement in the formulation of a national public health strategy and plan of action. The vision for participation in health is summed up in the following statement:

> The formulation and implementation of national health strategies and plans of action should respect, *inter alia*, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12 [referring to the right to health in the ICESCR]. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States (UN Committee on Economic, Social and Cultural Rights, 2000:art.54).

This view is also reinforced by Paul Hunt, the United Nation's Special Rapporteur on the right to the highest attainable standard of health from 2002 to 2008, and Senior Human Rights Advisor to the Assistant Director-General for the WHO from 2011 to 2013. As Special Rapporteur, he argued that the presence of a national plan that is widely consulted and developed with participation is an important indicator of a human rights approach to health systems (Hunt & Backman, 2008). Hence, within a human rights framework participation becomes an obligation of the state, which has a duty to put in place mechanisms for participation (Backman et al., 2008; Potts, 2008a).

Helen Potts's monograph on participation and the right to health elaborates on participation as a right central to the right to health (Potts, 2008a). Potts emphasises that this means that citizens have a right to participate, but also that "it is the State has the ultimate obligation to guarantee the realisation of the right to health, and to develop the institutional mechanisms to ensure that participation takes place" (Potts, 2008a:4). As part of this obligation, Potts argues that there should be a legislative requirement for participation and that an independent body should develop guidelines for a fair and transparent participatory process. Finally, Potts stresses the importance of a process that includes methods that enable group-specific participation, thus ensuring that marginalised groups are able to participate. Backman and colleagues (Backman et al., 2008) argue along the same lines, identifying participation as one of the key rights that should feature in health systems.

In South Africa the right to health and the right to participation became enshrined in the Constitution (South African Government, 1996). Furthermore, South Africa ratified the *International Covenant on Economic, Social and Cultural Rights* (UN General Assembly, 1976) in 2015 and is thus obliged to fulfil the obligations of the Covenant.

The right to participation is also central in the *International Covenant on Civil and Political Rights* (UN General Assembly, 1966), which South Africa ratified in 1998. The Covenant obliges states that have signed it to provide citizens with a right to participate in public affairs and provide effective opportunities to do so.

Furthermore, the right to participation is considered a core principle of human rights. A United Nations High Commissioner for Human Rights report to the UN General Assembly states that "participation in political and public affairs underpins the realization of all human rights and is inextricably linked to them" (United Nations High Commissioner of Human Rights, 2015: para 13). Within international human rights law, the right to participation has an elevated position and can be considered a supra-normative right.

The African Charter on Human and People's Rights (Organization of African Unity (OAU), 1981), which South Africa signed in 1996, further stipulates that states must promote participation by ensuring, through teaching, respect for rights and for people to understand these rights (London et al., 2012; Burnell, 2017).

A human rights approach shares many features with participatory democratic theory. However, it adds an important aspect by situating participation as a right, which means that people can claim rights as rights holders, and that duty bearers such as the state have a duty to fulfil these rights. Consequently, the state has an obligation to enable participation and put in place mechanisms for participation. A rights-based approach is important in that participation is not only an 'invitation', but rather an integral and human right. Thus, it is important to consider whether a form of participation that is rights-based offers different opportunities than forms which are not situated within a rights framework. This is also important in relation to health committees, which could be viewed as structures that are part of fulfilling the obligation of putting in place mechanisms for participation, which is outlined in *General Comment 14*.

The human rights framework adds a further component to understanding participation in health by conceptualizing it as participation in governance (priority-setting, planning, implementation, policy development and accountability). It is clear, that where some forms of participatory democracy views participation within a limited scope (for instance local institutions), a human rights framework also consider participation to occur at higher level including at policy level (Hunt & Backman, 2008). In addition, the human rights framework adds an accountability role by listing 'evaluation' of health strategies as an area of participation. This conceptualisation is important to consider in relation to health committees because it provides a way to assess these structures' roles and influence.

2.2.3 A Primary Health Care approach to participation

In developing countries, participation is mostly framed as community participation and aligned with a PHC approach. The main document outlining a Primary Health Care approach to participation is the Alma-Ata Declaration, signed by 134 countries in 1978 (World Health Organization, 1978). The Alma-Ata Declaration conceptualised Primary Health Care as comprehensive, universal and affordable health care for all. In addition, the declaration outlines the relationship between participation and PHC by conceptualising individual and collective participation as both a right and a duty. The declaration places emphasis on participation in planning and implementation of health care. Further, it highlights that participation entails control of Primary Health Care:

> [Primary health care] requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national, and other available resources; and to this end develops through appropriate education the ability of communities to participate (World Health Organization, 1978:ssVII(5)).

It is clear that the Alma-Ata Declaration shares many similarities with the human rights approach in its description of what participation entails – namely involvement in planning and implementation of health care. Further, the Alma-Ata Declaration talks about participation as control, thus suggesting a form of participation consistent with what Pateman calls 'full participation'. An important aspect of the PHC approach is that it emphasises *community* participation, something that can be viewed as putting emphasis on collective action. However, there is limited attention to defining what a 'community' is and no acknowledgement of communities as potentially consisting of many different groups, but rather an assumption that a community is a homogeneous entity.[6] The focus on community participation in the PHC approach resonates strongly with health committees, which are based on community representation. Additionally, health committee participation is focused on primary health care facilities.

After the Alma-Ata Declaration, participation was viewed as a central part of PHC. The declaration was considered an important framework for providing health care in particular to disenfranchised people such as people in developing countries, and in particular in rural areas. However, opposition to its principle soon emerged. As noted by Hall and Taylor:

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[6] The concept of a community is sometimes treated as if communities were homogeneous entities. This is problematic as it means that limited consideration is given to the presence of many different groups and individuals that may or may not share the same values, beliefs and interests. Considering communities as homogenous entities also fail to take power dynamics into consideration. Though I use the term community, this does not imply an understanding of a homogenous group of people. Rather, I consider any community, including a geographically defined community as is the case here, to be a group of people consisting of individuals with many different identities, identifications and senses of belonging. This understanding of community by nature implies the necessity to consider different interests and groupings within any given community and to consider power dynamics. When I refer to communities, I refer to a geographically defined group of people.

> Almost as soon as the Alma-Ata Conference was over, PHC was under attack. Politicians and aid experts from developed countries could not accept the core PHC principle that communities in developing countries would have responsibility for planning and implementing their own healthcare services (Hall & Taylor, 2003:18).

Many economic, political and other factors challenged the implementation of PHC. These include a shift to market-driven policies with an emphasis on user fees and cost recovery (Banerji, 2003). In 2000 the World Health Organization (WHO) abandoned the use of PHC as a means for delivering healthcare to resource-poor countries. However, as noted by Fee and Brown (2015), the PHC approach is still influential in many national health systems. PHC is also noted to have contributed to a more comprehensive and integrated health system and focusing on reaching the poor. Health improvement have also been achieved, for instance in child health and immunisation (Lawn et al., 2008). However, Lawn and colleagues (2008) also note that community participation is argued to be one of the weakest links in implementing PHC.

Recently, the role of participation has re-emerged in the WHO. Debates about the so-called health system's blocks have let scholars to argue that community participation should be considered part of the building blocks that make up health systems. Calls for this was, for instance, voiced at the Third Global Symposium on Health Systems Research (2014). Participation also features in WHO's framework on people-centred health services. The document cites social participation as a way of strengthening health care and further states that "strengthening governance requires a participatory approach to policy formulation, decision-making and performance evaluation at all levels of the health system" (World Health Organization, 2016:s6). The WHO also reaffirmed its commitment to PHC at a global conference in 2018 to mark the 40th anniversary of the Alma-Ata Declaration. The Global Conference on Primary Health Care in Astana, Kazakhstan, produced a new declaration, the Declaration of Astana. Similarly, to the Alma-Ata Declaration, this statement views the participation of individuals and communities as important.

> We support the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health (World Health Organization, 2018:sVI).

In South Africa PHC was a central component of the restructuring of the post-apartheid health system (Department of Health, 1997). According to Ncayiyana (2008), the country has accomplished "a fair amount" – to use Ncayiyana's words – in restructuring the health system according to PHC principles.

Together the three approaches to participation (participatory democracy, human rights and Primary Health Care) can be viewed as providing a common linked conceptual understanding of participation in health. All three approaches identify influence in decision-making as the defining characteristic of participation. Participatory democratic theory situates participation as a formal engagement between the state and its citizens, which is viewed as a way of 'deepening democracy' and provides an alternative to purely representative democracy. A human rights understanding extends this notion of citizenship by situating participation as a right. Furthermore, it argues that participation should take place at different levels, and include involvement in priority setting, planning and implementation, and should also occur at policy level. A human rights framework is important in that it obliges the state to put in place mechanisms for participation. Both the human rights framework and the PHC framework emphasises participation at both individual and community level. The PHC framework emphasises participation at primary care level and equates participation with 'control of primary health care'.

Thus, together these approaches are useful to conceptualise participation in primary health care level as involvement decision-making in priority setting, planning and implementation of health services – in health governance. Health committees, where community members and health officials engage around issues related to health governance and service delivery, could be considered a form of rights-based democratic practice at primary health care level. The question of how much influence participatory structures should have remains an unresolved issue. The PHC framework and some democratic theorists view participation as entailing full control over decisions, whereas the human rights framework frame it as influence (in the decision-making process). When I talk about conceptual frameworks or understandings of participation in this thesis, I refer to a participatory democracy, a human rights and a PHC approach.

While this thesis has chosen a PHC and human rights approach to understanding participation, it is important to note that there are alternative ways of framing participation.

The empowerment frame is one such understanding. The empowerment frame may at times coalesce with the PHC and human rights approach in understanding participation to be about influence in decision-making, but empowerment can also entail the right not to engage in decision-making when the conditions are not right.

Having outlined conceptual approaches to participation, I will below give an account of how participatory mechanisms were introduced in post-apartheid South Africa.

2.3 Participation in post-apartheid South Africa

The apartheid state was exclusionary, the very opposite of what participation entails (Burnell, 2017; Scott, 2009). Its governance was based on excluding vast sections of the population from both the economic and political spheres, based on racial classifications. In contrast, the post-apartheid state has through legislation introduced aspects of participatory democracy. First, the Constitution outlines that "The National Assembly must facilitate public involvement in the legislative and other processes of the Assembly and its committees" (South African Government, 1996:ss59(1)(a)). Other sections outline similar public involvement in the National Council of Provinces (the upper house of the South African parliament, representing the provinces) and provincial legislatures. Provisions for participation in local government is also made in that the Constitution stipulates that local government must "encourage the involvement of communities and community organisations in the matters of local government" (South African Constitution, 1996:ss152(1)(e)). Thus, as noted by Calland:

> South Africa's constitution asserts that public participation is a cornerstone of a democratic government. Citizens, including the weak and unorganised, have a right to participate in the legislative process – beyond episodic participation at election time (Calland, 1999:61).

At the municipal level, participation is elaborated on in the *Municipal Systems Amendment Act*, *No 33 of 2003* (2004) and the *Municipal Structures Act, No 44 of 2000* (2000). Here it is stated that communities must contribute to the decision-making process of the municipality. It is further stipulated that municipal Councils must consult local communities about service delivery. Public participation at local government level takes place through ward committees, where 10 representatives – or ward councillors – are elected to form a ward committee

together with the relevant local government councillor. Furthermore, the *Municipal Systems Act, No 33 of 2003* (2004) requires participation in the integrated development plans. This Act talks about developing a culture of community participation of municipal governance that must complement representative government (*Municipal Systems Act, No 33 of 2003, 2004*:ss16(1)). This includes creating the conditions for the local community to participate in issues such as monitoring and review the municipality's performance, prepare its budget and make strategic decisions (2004:ss16(1)(a)). A *National Policy Framework for Public Participation* (in municipalities) (Department of Provincial and Local Government, 2007) outlines strategies to ensure that participatory processes are genuinely empowering.

At institutional level, participation features in structures such as school governing bodies, where parents are elected to form these bodies with the principal (*South African Schools Act, No 68 of 1995*, 1996), and community police forums, where community members are appointed by the police to establish forums (*South African Police Service Act, No 68 of 1995,* 1996). These can be considered structures somewhat similar to health committees as they operate at local institutional level. They also illustrate two different approaches to forming institutional participatory structures: through election and appointment.

2.3.1 Institutionalised community participation in the health system in South Africa

Participation is also an important feature in South Africa's health system. Institutionalised participation became a feature of the health system with the restructuring and creation of a unified post-apartheid health system. Participation in the health system is largely envisioned to occur at facility level. While the *National Health Act* (2004) makes provision for structures such as a National Health Council, a National Health Consultative Forum and provincial health councils and consultative forums, these are formed by government officials in case of the councils, while the forums are supposed to include stakeholders. There is no provision for community involvement. *The National Health Act* (2004) further prescribes the establishment of district health councils for each health district. The NHA allows for the Executive Council to appoint five additional members to the district health councils, but the Act does not stipulate whether these should be community representatives or on what grounds additional members should be appointed, nor does the *Western Cape District Health Council Amendment Act* (2013).

Community participation is a more prominent feature at facility level with hospital boards and clinic and health centre committees.[7] The imperative to establish these structures is outlined in the *National Health Act* (2004). Section 41 of the NHA prescribes the establishment of hospital boards, while section 42 of the NHA prescribes the establishment of a health committee at each clinic or a cluster of clinics. Health committees should be composed of the facility manager, a ward councillor (local government councillor) and community members. However, it is left to provincial departments of health to provide the actual legislation for health committees that is expected to outline their roles, functions and composition. There is no articulation between the National Health Council, provincial health councils, district health boards, hospital boards and health committees outlined in the NHA.

The rationale for introducing participatory structures in the *National Health Act* is provided in the *White Paper on Transformation of the Health System* (Department of Health, 1997) (henceforth also referred to as the White Paper), which preceded the NHA. The White Paper on Transformation of the Health System argues for the importance of active participation in PHC in a language similar to the Alma-Ata Declaration by referring to participation as entailing community involvement in "the planning and provision of services in health facilities" (Department of Health, 1997:ss2.5.2(a)). In line with participatory theory, the White Paper envisions participation in the health system as part of the democratisation process. Like *General Comment 14*, the paper emphasises peoples' participation in national policy and proposes both national health summits as well as provincial and district summits as mechanisms for public participation (ss2.5.3). In that sense, the White Paper presents participation in a way consistent with both the international human rights and the PHC framework. As with the Alma-Ata Declaration, participation in planning and prioritisation is part of the vision of community participation. Moreover, the White Paper is clear on conceptualizing health committees as representative bodies, acquiring their mandate through being elected by their communities. While the White Paper provides the rationale for community participation, it is evident that this is not reflected in the Western Cape Act on health committees. The Western Cape Act does not envision participation with elected

[7] The *National Health Act* uses the terms 'clinic' and 'community health centre committees', while the Western Cape Act uses the term 'health committees' and 'clinic committees'. In this thesis, the terms are used interchangeably, though I mostly use the term 'health committees'.

representatives and does not see participation as taking place at different levels of the health system.

A similar conceptualisation to the White Paper mentioned above is reflected in a *Draft Policy Paper on Health Governance Structures* (Department of Health, 2013) – henceforth this document will also be referred to as the National Draft Policy. Even though policies on health committees are the prerogative of South African provincial health departments, the policy paper is important to consider as it outlines the National Department of Health's vision for health facility boards and health committees. This framework envisions health committees as governance structures with roles in the planning and provision of health services, providing oversight and ensuring accountability. Initially, the Department indicated that the draft policy would become legislation, but the implementation of the policy was held back with reference to the National Health Department's limited power over health committee legislation.

Participation also plays a role in the re-engineering of South Africa's primary health care services, which is part of the National Health Insurance currently being implemented in South Africa (Department of Health, 2017). The re-engineering was initiated in 2010 after a ministerial visit to Brazil to learn from that country's success in improving the health of the population (Pillay & Barron, 2011). Though community participation does not feature strongly in the re-engineering of the primary health care services, the *White Paper on a National Health Insurance* (Department of Health, 2017) briefly refers to clinic committees in a section dealing with improving management and governance. The roles of committees are captured in the following paragraph, which refers to the *Draft Paper on Health Governance Structures*:

> Clinic Committees will be strengthened for all PHC facilities to provide advice and play an advocacy role for the communities they represent. They will also focus on public health campaigns in the catchment areas of their respective clinics. Guidelines have been developed on how these Clinic Committees will be strengthened and how they will function to represent the needs of communities (National Department of Health, 2017:s163).

Though health committees are considered to have an advisory role, there is little detail on what they can advise on. Furthermore, health committees seem not to be envisioned to have a role in oversight and accountability.

Overall, participation is awarded a limited place in the *National Health Insurance Policy.* This is in contrast with the Brazilian health system, which was intended to be the template for the re-engineering of the primary health care services. Yet the Brazilian health system is far more participatory. In the Brazilian model municipal health councils have strong decision-making powers in budgets and health plans (Cornwall, 2007). Part of that country's success in improving health is attributed to its participation structures (World Health Organization, 2008).

Health committees are also included in the *Ideal Clinic Manual* (Department of Health, 2018) a quality improvement tool for primary health care services (Department of Health, 2018). All clinics are expected to adhere to a checklist for health committees. Again, there is some inconsistency on health committee roles when compared to the National Draft Policy (2013) and the White Paper (1997). There are also important discrepancies between the Western Cape Act and the *Ideal Clinic Manual* (Department of Health, 2018). For instance, committees are according to the *Ideal Clinic Manual* expected to be involved in addressing complaints, discussing human resources and community needs, and how operational plans should meet these requirements (Department of Health, 2018).

Policies on health committees in South Africa's nine provinces, produced between 2009 and 2015, generally conceptualise health committees as governance structures with roles in the planning of health service delivery and in providing oversight. Most provincial policies (Haricharan, 2015a) also envision health committees as accountability structures with some involvement in managing complaints and/or in monitoring and evaluating service delivery. Conceptualising health committees as governance and accountability structures is consistent with the National Draft Policy (2013) and the international human rights and PHC frameworks. Appendix A provides a more detailed overview of governance and oversight roles envisioned by the provincial policies and Acts.

2.3.2 Health committees in the Western Cape

The Western Cape Province was the first South African province to draft a policy framework for community participation structures in 2008 with the *Draft Policy Framework for Community Participation/Governance Structures in Health* (henceforth the Draft Policy)

(Western Cape Health Department, 2008). The Draft Policy envisioned a tiered structure for community participation. Health committees were said to be elected by patients and communities. Four clear roles were outlined suggesting that health committees were: a) to provide governance; b) to take steps to ensure that the needs, concerns and complaints of patients and communities were addressed by the facility; c) to foster community support for the facility and its programmes, and finally; d) to monitor the performance, effectiveness and efficiency of the facility. It is clear that this framework resonated strongly with the participatory democratic, human rights and PHC approaches outlined in this literature review and with the conceptualisation of health committees as governance structures.

However, this policy was never implemented, leaving health committees in a 'policy vacuum', which had wide ranging effects on them (Haricharan, 2012; Meier, Pardue & London, 2012). After a protracted period of engagement between the provincial Health Department and community structures, the Western Cape Health Department passed the *Western Cape Health Facility Boards and Committees Act* (2016), (henceforth the Act) which amended the existing *Western Cape Health Facility Boards Act* (2001) to include health committees within its ambit. With the legislation, health committees became legally constituted participatory forums. Although the rationale for community participation is provided by the 1997 White Paper, the Act fails to turn the conception of participation in the paper into a reality in the Act.

In comparison to other provincial legislation, draft legislation and guidelines on health committees, the 2008 Western Cape draft policy and the national policy on health committees, the Western Cape Act assigns weaker roles in governance and accountability to health committees (Haricharan, 2015a). Also, similar to six other provincial policies, the Western Cape policy adopts an appointment model, where the provincial health minister, also called the MEC[8], appoints health committee members. A more detailed analysis of the Western Cape legislation is presented in Chapter 5.

[8] 'MEC' is an abbreviation for Member of Executive Council. MECs are also referred to as provincial ministers. In this thesis the terms are used interchangeably.

In short, then, the policy landscape for health committees is complex. The Western Cape provincial legislation is inconsistent with national policy frameworks such as the *Draft Policy on Health Governance Structures* (Department of Health, 2013), the *White Paper on a National Health Insurance* (Department of Health, 2017), and the *Ideal Clinic Manual* (Department of Health, 2018).

While health committee legislation is relatively new, community participation in health has a long history. During the apartheid era communities and health professionals opposed to the apartheid system organised themselves to provide alternative services to the official government health services, as the latter, based on the state's racial policies, provided limited and inadequate care to large parts of the population, and no health care to residents who were injured during anti-apartheid protests (see Baldwin-Ragaven, de Gruchy & London, 1999). Health committees have been functioning in the Western Cape since around 1989 and coordinated under an umbrella body for health committees, the Cape Metro Healthcare Forum (CMHF), since 1992. However, the CMHF was largely inactive during the research period, though there were attempts at reviving the structure.

This section has outlined how post-apartheid South Africa's Constitution and legislative framework emphasise participation at various levels of government as well as at institutional level, giving effect to the internationally recognised right to participation. It has further described how the NHA (2004) has prescribed mechanisms for community participation in health structures at facility level. Below I review empirical research on participation.

2.4 Participation in practice: considering the empirical evidence

This section reviews empirical research on participation both globally and in South Africa. This includes experiences outside and within the health sector. I include grey literature, where much relevant literature on health committees is located. Furthermore, I include literature outside the health system, because lessons from these invited spaces have relevance to participation within the health system.

2.4.1 Conceptual understandings of participation in health

As noted by George and colleagues (George et al., 2015b), community participation in health is under-theorised. However, there are some attempts at theorising participation. Several authors contrast an empowerment model with a more instrumental or target-orientated model (Morgan, 1993; Oakley, 1989; Rifkin, 1996; Rifkin, 2001). The utilitarian model is mainly concerned with outcomes, while the empowerment model is concerned with the process. Morgan criticises the utilitarian model for seeking a technocratic solution to a political problem, while she perceives the empowerment model to be liberating and transformative (Morgan, 1993).

Different typologies are used to characterise different forms of participation. The distinction between formal and informal participation is central in much of the literature. Formal participation includes involvement by those who are officially sanctioned and operate through structures within the health system. Informal participation, on the other hand, is mobilisation of people emerging from communities (Gaventa, 2006), social movements (Brown & Zavestoski, 2004) and civil society organisations (London et al., 2012). Sometimes informal participation takes the form of consumer groups mobilising (Allsop, Jones & Baggott, 2004) or spontaneous public protests.

Formalised invited participation has emerged and gained popularity in health systems. There are many examples, including Bangladeshi health watch committees (Mahmud, 2007), Brazil's health councils and conferences (Cornwall & Shankland, 2008), and the Philippine's local health boards - though it is important to note that there is only one NGO representative representing the community - (Ramiro et al., 2001).

Health committees are a distinct form of community participation, but community participation can take many forms from involving communities in short-term intervention projects to long-term engagement in governance or oversight. Health committees can be considered a type of formalised invited participation, which George et al. (2015b:160) define

as groups that contain some layperson representation, having a formal link to the government and existing to improve local well-being.[9]

In Africa the predominant form of community participation is health committees linked to primary health care facilities. Health committees exist in most East and Southern African countries (Loewenson et al., 2014), though only three of 16 countries included in their study have legislation on health committees, South Africa being one. Reports from EQUINET[10] (Loewenson et al., 2014; Community Working Group on Health et al., 2017) suggest that contentious issues for health committees in the region are how these committees are constituted (through appointment or election), their composition and which sectors should be represented. Practitioners generally agree that health committees should be governance and accountability structures. They are generally perceived as representing the needs of the community, facilitating dialogue between service providers and recipients, overseeing service delivery, and be involved in budgeting and planning.

Formal participatory structures in the health system are increasingly seen as governance structures in countries such as the Philippines (Ramiro et al., 2001), Brazil (Coelho, 2007; Cornwall, 2007) and in many African countries (Kessy, 2014; Mdaka, Haricharan & London, 2014). An important aspect of the governance model is that participation is on-going, in contrast with forms of participation that are time-limited or ad hoc participation in health intervention projects (Cooke, & Kothari, 2001); and that the governance model is facility-based.

[9] When this thesis uses the term community participation it uses it as a generic term, which encompasses many forms of participation involving community members. When it uses the term health committees, it refers to committees that fulfil the criteria outlined by George et al. However, it is important to note that literature often talks about community participation when referring specifically to health committees. Many participants in this study also used the terms interchangeably. For this reason, there is at times a conflation between the terms community participation and health committees in this thesis.

[10] EQUINET stands for the Regional Network on Equity in Health in East and Southern Africa, a network of professionals, civil society members, policy makers, state officials and others within the region who have come together as a catalyst for equity, to promote and realize shared values of equity and social justice in the health sector.

2.4.2 Degree of participation

The conceptual approaches outlined above view participation as entailing influence in decision-making. Many scholars have developed models to assess the level of participation that resonates with these approaches by assessing the degree of influence. The seminal work in this context is Arnstein's (1969) 'ladder of citizen participation'. Arnstein's ladder describes how much say communities have in decision-making and how much control they have. There are three main categories: non-participation, tokenism, and citizen power, with each level divided further into rungs, totalling eight rungs. At the lowest level engagement (therapy, manipulation) is described as non-participation, where communities are manipulated into cooperation. Higher up the participatory ladder is 'tokenism', where people are informed about decisions made and possibly consulted. At the most participatory level, people are in control and have decision-making power.

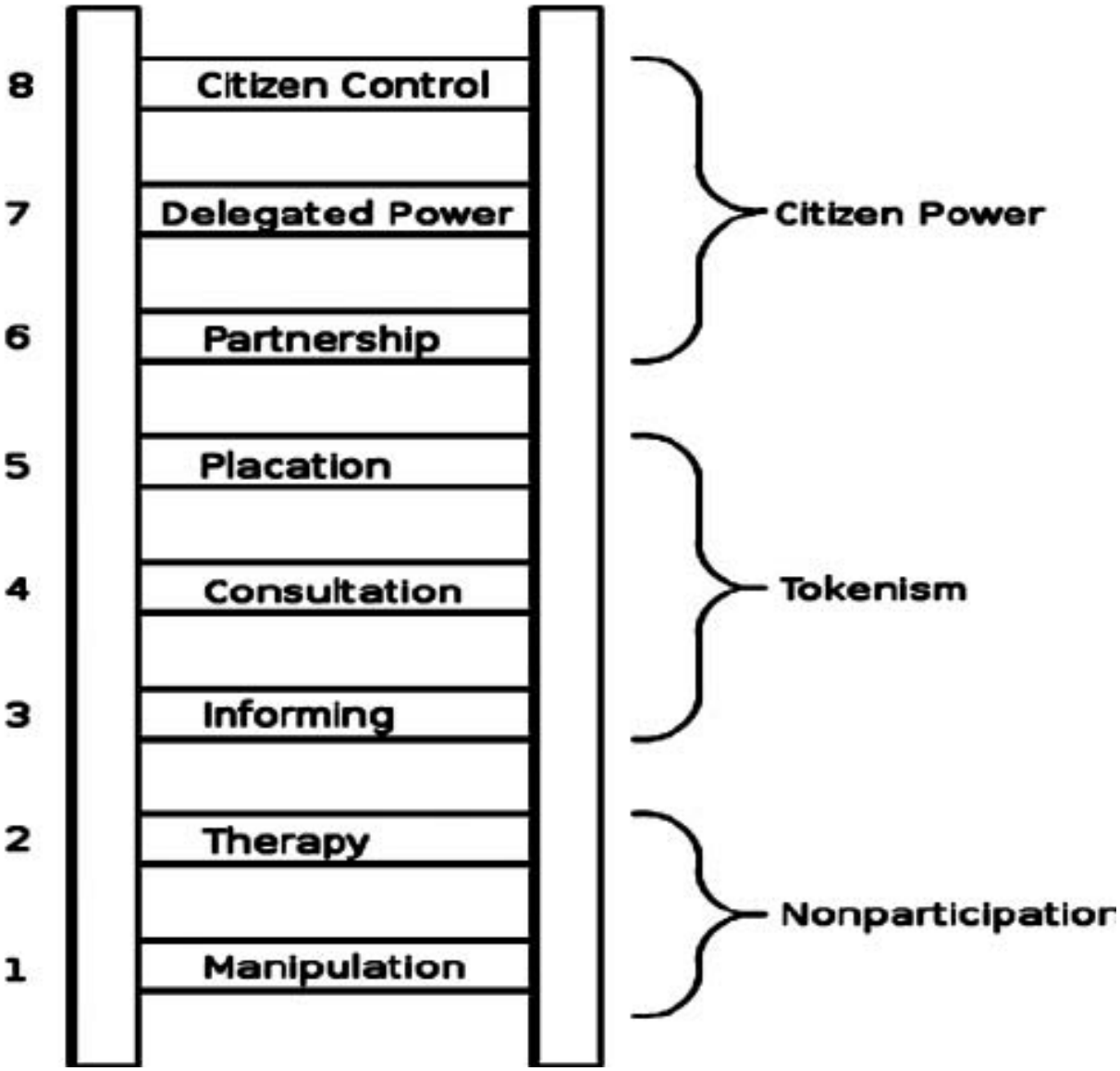

Figure 1: Sherry Arnstein's ladder of participation (1969:217). Image from Researchgate.net

Pretty's (1995) model consists of seven forms of participation, similar to Arnstein's: manipulative participation, passive participation, participation by consultation, participation for material incentives, functional participation, interactive participation and self-mobilisation. Oakley (1989) operates with four levels: marginal participation, limited and transitory participation, substantive participation, and structural participation. Loewenson's (2000) model resembles Arnstein's in focusing on control and decision-making. It consists of no participation, receiving information, consultation, advisory role, joint planning, delegated power and control. All models share a common approach of framing a gradation where greater control and influence over decisions are manifest at higher levels of participation.

None of the models consider that different situations and contexts may warrant different degrees of participation.

2.4.3 Research on health committees' decision-making

Much research elaborates on influence in decision-making, with most authors agreeing that participation often entails limited decision-making. Authors of a systematic review (McCoy, Hall & Ridge, 2012) surmised that most community participation takes place 'on the lower rung' of Arnstein's ladder of participation. This pattern is also consistent with South African findings on health committees (Haricharan, 2012). About 70% of health committee members' activities in Cape Town involved assisting the clinic with issues such as cleaning the clinic, acting as security guards, doing administrative work and managing queues.

Similarly, research on how communities participate illustrates that they rarely play roles consistent with those outlined in conceptual understandings of participation. George and colleagues (George et al., 2015a), for instance, found in their review that while most communities were involved in health interventions, this largely entailed involvement in implementation, rarely in identifying problems or coming up with interventions. Neither were they involved in monitoring or evaluation or in governance. Overall, the literature indicates that communities have limited influence in decision-making and play roles that are inconsistent with a PHC approach.

Much research on health committees focuses on assessing the outcome of participation in terms of improved health services or health outcomes. This illustrates that participation in health is often viewed and practised within a target-orientated conceptualisation. There is consensus that when assessing health committees in terms of their impact on health services and outcomes, they can be successful. Two recent reviews of health committees found evidence of their potential effectiveness in improving health services. McCoy and colleagues (2012) lamented the poor quality of the studies in their systematic review, but nevertheless concluded that, "nonetheless, taken together, the four studies [that they used to assess impact] provide some strong evidence that HFC [Health Facility Committees] can impact positively on the quality of care provided and on health outcomes" (McCoy, Ridge & Hall, 2012:456). Similarly, George and colleagues (George et al., 2015b) found that the operation of health

committees resulted in more accessible and acceptable health services but contributed less to the quality of services. However, in both papers there was limited attention to how the committees contributed to these improvements. The two reviews did not distinguish between different forms of participation, such as institutionalised versus non-institutionalised. There is little attention to what form of participation led to improved health services. For instance, given that studies have found that participation mostly occurs on the lower rungs of Arnstein's ladder, is it possible that improvements result from a form of 'participation' where people contribute their time as an extra pair of hands at the clinic or in health intervention projects.

There is some evidence of health committee effectiveness in the Southern African context. A study from Zimbabwe (Loewenson, Rusike & Zulu, 2004), for instance, found evidence that facilities with health committees had better health service use, more staff and better health indicators. However, it is important to note that this is an observational cross-sectional study, which provides weak evidence of causality. Glattstein-Young's (2010) study of three health committees in Cape Town argued that committees had the potential to impact positively on the realisation of the right to health, primarily through improving accessibility and availability, and to a lesser degree acceptability and quality. However, the same underlying factors that enable health committees to function well (e.g. committed clinic leadership) might also result in better outcomes, so the causal role of the health committee might be confounded. In contrast with these studies, Kessy's (2014) study on the impact of health committee participation in health governance in Kenya provides evidence that health committees struggled to fulfil their governance role and the author cites power relations as one of the reasons for this, but without going into detail. This points to the possibility that it may not be through health committees' governance role per se that they impacted on service delivery.

There are many studies on community monitoring (e.g. Bjorkman & Svensson, 2009; Garg, & Laskar, 2010; Khunte & Walimbe, 2012), but they do not necessarily focus health committees. However, a systematic review of community accountability mechanisms, which focused mainly on health committees and other groups, found little empirical evidence of the committees' ability to function as accountability structures, but suggested that they had a potential role to play (Molyneux et al., 2012).

2.4.4 Factors impacting on health committees

There is consensus in both the international reviews (McCoy, Hall & Ridge, 2012; George et al., 2015b) and in the South African literature (Boulle, 2007; Padarath & Friedman, 2008; Glattstein-Young, 2010; Haricharan, 2012) that poor functionality of health committees impact on their effectiveness. Poor functionality is here understood in terms of problems with how committees operate: infrequency of meetings, poor attendance at meetings, high turnover of members, limited size of committees, problems with administrative issues such as minute-taking and financial management.

Numerous factors contribute to this. South African studies point to lack of clarity on role and function, staff perceptions and attitudes, resources, capability of community members, poor linkages to communities, top-down approaches to decision-making, dominance by medical professionals, limited resources, limited capacity and skills, attitudes of health workers towards participation, limited co-operation from health services, and lack of support and agreement on a definition of participation (Boulle, 2007; Padarath & Friedman, 2008; Glattstein-Young, 2010; Haricharan, 2012). Studies in other African countries identify similar barriers. Studies in rural Tanzania (Kessy, 2014) and Uganda (Kapiriri, Norheim & Heggenhougen, 2003) highlight poor capacity and skills as the major barriers for effective participation in governance and planning. Further, Kessy argues that health was mainly seen as a medical matter and that there was no partnership model between committees and health facilities. Kapiriri and colleagues (2003) reported that economic, social and cultural barriers hindered many from participating and led to the local elite dominating the participatory planning process. A 2013 study from Tanzania (Kamuzora et al., 2013) found participation in priority-setting to be complicated by limited time for deliberations, lack of feedback from health facilities, and health professionals' reluctance to involve community representatives in setting priorities. Studies from Tanzania and Kenya (Kilewo & Frumence, 2015; O'Meara et al., 2011), which focused on focused on health committees' role in developing and implementing health plans and policy planning, respectively, identified the following barriers: lack of capacity, poor communication, unstipulated roles, lack of resources and problems with reconciling community priorities with pre-determined national priorities.

2.4.5 Adversarial vs collaborative engagement with the state in South Africa

In this section, I turn to debates around different forms of engagement between the state and its citizens, debates that are not particular to health committee participation. I do so to highlight debates around invited vs claimed participation, which also have relevance for health committees.

Health committee participation takes place in a context where there is a proliferation of different forms of participation and an ongoing tension between a collaborative and an adversarial relationship with the state. Social movements and popular demonstrations have proliferated. These social movements often draw strength from a collective identity (Ballard et al., 2006; Thompson & Tapscott, 2010) and according to Barnes (2007) are often based on 'oppositional consciousness', indicating that social movements often position themselves in opposition to the state, unlike invited spaces which are created to foster collaboration.

Social movements in South Africa have their roots in relationships forged during the struggle against apartheid, when social movements worked with the African National Congress (ANC), which became the post-apartheid governing party. As noted by Ballard and colleagues (Ballard et al., 2006), the immediate post-apartheid relationship was mainly characterised by collaboration between civil society and the state. When the ANC became the governing party, these alliances continued. However, the authors argue that new social struggles quickly emerged, focused on social and economic issues facing the poor and the marginalised such as land, housing and health. In this struggle some movements opted for an adversarial relationship with the state, while some sought collaboration and others used a variety of strategies. "Social movements' engagement with the state fall on a continuum between in-system collaborative interactions on the one extreme, and out-of-system adversarial relations on the other" (Ballard, Habib & Valodia, 2006:405).

A social movement that is particularly relevant in this context is the Treatment Action Campaign (TAC), a social movement in the sphere of health formed in 1998 to campaign for access to antiretroviral medicine (ARV) for HIV-positive South Africans. It is considered one of the most successful social movements in the post-apartheid era (Friedman & Mottiar, 2006). The TAC is an example of a social movement that has used both adversarial tactics and collaboration with the state. It has used the courts to force the government to provide ARVs yet collaborated with the government against pharmaceutical companies and worked

with the government in the rollout of ARV treatment. The TAC has through mass mobilisation and litigation influenced the state's policy with regards to the treatment of HIV-positive patients.

2.4.6 Experiences with participation in South Africa

Experiences with participation in structures related to local government in South Africa can be useful in relation to health committee participation as these can illustrate important issues related to invited participation. While there is limited research on health committees in South Africa as democratic governance structures, there is more research on community participation in local governance.

A group of South African scholars, mainly studying local governance, take a critical view of invited participation (Thompson and Tapscott, 2010; von Lieres, 2007; Williams 2007a and 2007b; Piper and Nadvi, 2010; Katsaura, 2015; Sinwell, 2015). For instance, Sinwell (2015) argues that despite a strong legislative framework for invited participation, this form of citizen participation has failed. The main form of engagement between citizen and state is, according to these scholars, increasingly occurring through mass mobilisation and protests, which sometimes turn violent (Thompson 2007; von Holdt, 2011). According Thompson and Tapscott (2010), protests and social movements have in many instances rendered invited spaces irrelevant. Tapscott views the upsurge in social protest in South Africa in the last decade as a reflection of the failure of formal institutionalised participation.

Tapscott further argues that the failure of invited participation is not, at least at face value, a result of political neglect (Tapscott, 2007). In contrast, von Lieres (2007), writing about participation in land policy and health, argues that the limits of the state's democratisation strategies have become apparent and that there is a gap between legal assurances of participation and the actual inclusion of poor citizens in democratic processes. Others posit that invited spaces are 'sterile' and 'sedative', or that claimed spaces are more effective forms of participation than invited participatory spaces because authorities tend to listen more to these (Thompson & Tapscott, 2010).

Authors critical of invited participation provide several reasons for their perceived failure. Elite capture is mentioned as one reason (Williams, 2007a; Katsaura, 2015; Morange, 2015).

In the case of local government, capture by local politicians is put forward as an explanation (Tapscott, 2007). Uneven power relations between actors and beliefs amongst citizen that invited participation does not produce meaningful results are other explanations (Williams, 2007a). Piper and Nadvi (2010) assert that participatory institutions are already disempowered at the outset, because they have limited power and resources.

These authors also challenge us to consider the rationale behind states' interest in engaging with citizens through participation, suggesting that states may not engage in participation with the purpose of 'deepening democracy'. Williams (2007b), for instance, claims that participatory spaces are ceremonial, while Katsaura (2015) calls them ritualistic spaces in which participation become a space for venting frustrations, defusing resistance and an outlet for anger. In Katsaura's words, participation in these spaces becomes 'Nurofen'.[11] "They can be depicted as platforms that enable failed of failing governments to still reproduce themselves, regardless of their failures" (Katsaura, 2015:108). Similarly, Gervais-Lambony (2015) argues that democratic spaces often become spaces for airing grievances and an outlet for citizen rage. Von Lieres is less pessimistic but does warn that "new democratic institutions and spaces do not automatically guarantee democratic self-representation by marginalized groups" (2007:238). The critique of invited spaces is also based on an argument that participation often is used to legitimise government decisions. For instance, Thompson (2007) argues that invited participatory spaces can become rubber-stamping factories that legitimise government decisions rather than promoting change.

2.4.7 Invited spaces as complex spaces with possibilities and constraints

In this section I turn to the international literature to illustrate debates on invited spaces. On an international level, an important contribution to the debate on participation comes from a series of papers published in *Participation. The New Tyranny* (Cooke & Kothari, 2001). While the book is concerned with participation in international development programmes, it raises questions about participation that are also foundational to community participation in health. These include questioning whether participation is a key to equity, as assumed by democratic theories, and whether participation is empowering or manipulative.

[11] Nurofen refers to a painkiller.

A follow up to the debate was published three years later (Hickey & Mohan, 2004). In this follow-up book, some authors remain pessimistic about the potential of participation. Cooke, for instance, argues that community participation has become a technocratic solution to a political problem (Cooke, 2004). Others are more optimistic. Gaventa's chapter describes participation in governance as a new promising form of participation (Gaventa, 2004). Gaventa argues that viewing participation as citizenship offers a new focus on participation as engagement between state and citizens. Cornwall and Coelho's book *Spaces for change? The politics of citizen participation in new democratic arenas* (2007) explore citizen participation further. They argue that there has been a proliferation of new spaces for citizen engagement at the interface between state and society. Some of the book's chapters describe community participation in the health system, including Brazilian health councils, Bangladeshi health watch committees and South African health facility boards. In general, the book views participatory structures - or invited participation – positively. The editors see these invited spaces as new democratic spaces or participatory spheres:

> Common to all [chapters in the book] is a conviction that participatory fora that open up more effective channels of communication and negotiation between the state and citizens serve to enhance democracy, create new forms of citizenship and improve the effectiveness and equity of public policy (Cornwall & Coelho, 2007:5).

However, the chapters in the book are also based on a premise that the potential of invited spaces depends on a number of factors. An important aspect in several chapters is an interest in exploring the preconditions that need to be in place, as Cornwall and Coelho ask: "what does it take for marginalized and otherwise excluded actors to participate meaningfully in institutionalised participatory fora and for their participation to result in actual shifts in policy and practice?" (Cornwall & Coelho, 2007:8). The conditions mentioned include an appropriate design of the participatory space, having rules for decision-making processes, facilitation of participation of marginalised groups, and adequate social mobilisation outside the spaces. People's ability to recognise themselves as citizen who have agency and skills is also considered an important precondition as is their understanding of participation and motivation for entering the invited space. Importantly, the chapters in the book also warn that invited spaces are never neutral, but places of power. Referring to an earlier article by Coelho (2002) they argue: "As 'invited spaces', the institutions of the participatory sphere are framed

by those who create them and infused with power relations and cultures of interaction carried into them from other spaces" (Cornwall & Coelho, 2007:11).

Furthermore, the authors note that the possibility inherent in the invited space is linked to the past experiences and the dispositions of actors. They point out that "citizens who have been on the receiving end of paternalism or prejudice in everyday encounters with state institutions may bring these expectations with them into the participatory sphere" (Cornwall & Coelho, 2007:12). This point may have resonance in post-apartheid South Africa. Perhaps not surprisingly, a paper on South African hospital boards (Williams, 2007a) argues that a legacy of paternalism and racism is present in these new spaces. Williams found that some black people would not participate in hospital boards, because they felt they did not have the necessary skills. Providing training, resources and support can assist in making popular participation viable, but Cornwall (2007) argues that it also requires a state that is responsive to participation and facilitates active citizenship. She argues that the state has a role to play in developing political consciousness, critical consciousness and consciousness of being a citizen and in stimulating the cultural change needed for participation to work (Cornwall, 2007:73). This point of view corresponds with the South African state's duty to promote human rights, which is a uniquely South African state obligation, outlined in the Constitution's Bill of Rights (South African Government, 1996).

Coelho and Cornwall are also concerned with people's ability to participate. Coelho (2007: 51) claims that having influence – being able to participate – requires capacities for democratic citizenship and highlights that participatory spaces may be inherently intimidating to marginalised citizens:

> For people living in poverty, subject to discrimination and exclusion from mainstream society, the experience of entering a participatory space can be extremely intimidating. How they talk, and what they talk about may be perceived by professionals as scarcely coherent and relevant; their participation may be viewed by the powerful as chaotic, disruptive and unproductive (Cornwall & Coelho, 2007:13).

While *Spaces for change. The politics of participation in new democratic arenas* (2007), views participation as citizenship positively, they also sound a warning: they argue that participation is not always an extension of citizenship. Sometimes it can be associated with

shrinking state responsibility and the exemption of the state as guarantor of rights (2007:5). Dagnino (2005) similarly contends that users may become self-providers and consumers of health services rather than claims-making citizens.

A study by von Lieres and Kahane (2007) documented that marginalisation can in fact be perpetuated in invited paces. Their work, along with Mohanty's (2007) study, illustrates that representation does not automatically lead to having a voice: having a seat at the table is only a first step in participation. Additionally, both papers point to the importance of creating spaces that facilitate the participation of different groups, including the marginalised.

A prerequisite for active citizenship in invited spaces is citizens' capacity to represent and express issues. The issue of who represents who, and how they come to represent them, is therefore important. Representation is also linked to questions of the legitimacy of representatives and how they come to be representatives. As Cornwall and Coelho notice there is extensive literature on representation, but this literature focuses more on who are represented and who they represent; less on the processes through which some people come to represent others. In South Africa (Haricharan, 2015a), most provincial policies stipulate that the provincial health ministers should appoint health committees. There has been much contestation on whether health committees should be elected or appointed (Stinson, 2015). In practice, it is also unclear how health committees in the Western Cape are formed (Haricharan, 2012).

The issue of how health committees should be formed is debated in many contexts. Internationally, elections are said to be practised in Kenya according to Sohani (Sohani, 2009, quoted by McCoy, Hall and Ridge, 2012),[12] while participatory structures in Peru have some elected members (Iwami and Petchey, 2002), though there is limited information on the election process – in particular who constitutes the electorate. For instance, when Coelho, Pozzoni and Cifuentes, (2005) write about elected health council members, they refer to members who are elected to represent specific sectors (mostly civil society organisations). It is these sectors that elect their representatives. There is a dearth of information on the processes leading to electing these members, note the authors. Of importance is that when the

[12] It has not been possible to locate the original source for this information.

literature talks about elected structures this does not necessarily imply that the electorate consists of all people residing in a specific area.

The question on how to best ensure representative participatory structures – in particular in terms of ensuring representation of the most marginalised remain unresolved. Cornwall and Coelho (2007:15) argue that the literature on representation suggest that there is a strong argument that the direct democratic approach can best ensure the inclusion of less organised and vocal groups.

> The extensive literature on representation offers a range of perspectives on how best to ensure the inclusion of less organized and vocal groups. There is a current that argues for a more direct democratic approach: participatory sphere institutions should be open to everyone who wants to participate (Cornwall and Coelho, 2007:15).

Together then, current debates on invited participation argue that the effectiveness of this form of participation is dependent on many factors and linked to how some people come to represent others and their ability influence in decision-making. The literature highlights that invited spaces are complex spaces, and that giving careful consideration to their design and what happens in them is important for unlocking their potential. These factors are relevant to studies on South African health committees.

Positive experiences of invited participation are also evident in the literature. Of particular interest when considering invited participation in health is Brazil's experience. Brazil's participatory system consists of health councils at various levels of the system. These structures are viewed as oversight structure. In addition, Brazil's system consists of conferences, which begin at local level and take place throughout the system and ends with large national policy conferences. Representatives from lower levels are elected to represent communities at the higher level. The participatory system is noted by the WHO to have contributed to Brazil's progress in health (World Health Organization, 2008). While these structures face challenges, this seem in the main not to lead authors to view these challenges as evidence of failure of invited participation, though there are examples of authors who are critical of their potential. Notably, Kohler and Martinez (2015; Martinez & Kohler, 2016), who argue that health councils are inefficient due to number of factors similar to those identified in the South African health committee literature. Other authors are more optimistic

about their potential and frame Brazil's experience with participatory councils and conferences as an experiment with 'democratisation'. Wambler and Avritzer (2004:291) argue that the country has some of the most successful experiences with new democratic forms. In this line of engagement, several articles focus on how to improve the potential of these structures. Where much literature focuses on the Brazilian health councils, Cornwall and Shankland (2008) are concerned with the system of health conferences, which involved citizens in policy discussion. They note the potential of these council in ensuring community input in policy-making. The authors argue that participation along with a human rights approach is what makes the Brazilian system effective: "Brazil's rights-based approach to citizen participation engages citizens not as 'choosers', but as those who should be actively engaged in shaping policies and holding the state to account for delivering on them." (Cornwall & Shankland, 2008:2182). Cornwall and Shankland also argue that despite challenges, Brazilian health councils have remained political viable and resilient (2177).

In the participatory literature, participatory budgeting is often referred to as an example of an area where participation has been successful. In particular, the Porto Alegro participatory budgeting has been well-documented (Pateman, 2012). Nevertheless, Pateman argues that despite the proliferation of participatory budgeting, many projects are not very participatory. A systematic scoping review (Craig, Campbell & Escobar, 2017) note that despite the strong interest in participatory budgeting, there is lack of rigorous studies assessing their outcomes.

Fung and Wright (2003a), while highlighting that many collaborative structures lack sufficient power, also provide four successful case studies of Empowered Participatory Governance – spaces that can be considered invited spaces. These include case studies in schools, policing, environment and the workplace.

Thus, the literature offers two very different framings of invited participation. Where the South African literature on local governance mainly see challenges and the proliferation of claimed participation as evidence that invited participation is not feasible or effective, international literature, in particular on Brazilian health councils and conferences, see challenges as a call to identify improvements to invited participatory structures – to an ongoing process of 'deepening democracy'. The literature on invited and claimed spaces is thus contradictory: some authors claim that invited participation does not work, others suggesting that they are effective under certain circumstances.

2.4.8 Contradictory evidence: reframing the question

Furthermore, the argument that the proliferation of claimed spaces is evidence that people have rejected invited participation should also be considered. Rather, much of the literature suggests that invited participation work under certain circumstances. In other circumstances claimed participation may better be able to advance actors agenda, as the TAC's approach has highlighted (see for instance Geffen, 2010; Mbali, 2013). TAC's approach points to a different view of the invited-claimed and adversarial-collaborative dichotomy. This organisation works both in opposition to the government (as an adversarial structure), but also collaborate with the state. The organisation has created spaces, but also engage in invited participation. This suggest that some organisations successfully navigate the collaborative-adversarial dichotomy and make strategic choices on how to engage with the state.

Worth considering is also Piper and Nadvi's suggestion that participation is strengthened if it incorporates invited and participation. A similar argument is put forward by the Benit-Ghaffou and Mkwanazi (2015). Furthermore, a study in a South African township (Thompson & Nleya, 2010) found that residents undertake different forms of engagement with the state. While they prefer 'deliberative' engagement (invited participation), they may also choose protest when other forms of engagements fail. Thus, there are arguments that suggest that invited and claimed participation may co-exist and strengthen each other.

In a similar vein, Fung and Wright (2003c) argue that collaborative engagement (practised in invited participation) and adversarial engagement (often carried out in participation) are different forms of engagement and address different problems. Where adversarial engagement often addresses high-level issue and focus on claiming rights, invited participation is often concerned with joint problem-solving, often at local level.

This review of the literature on participation is useful to frame some core assumption for this thesis. Firstly, I posit that invited spaces take many different forms and function in different contexts and under different conditions. Attention to the design of specific spaces, the conditions and contexts under which invited participation takes place is important. Secondly, invited participation should not be seen in contrast to claimed spaces. Rather, these different

spaces should be viewed as different ways people express their citizenship in health. Thus, while this research focuses on invited participation, it considers this in relation to other forms of engagement.

Hence, the question of whether invited or spaces are preferable should not necessarily be approached as an either-or question, but rather as a question of when invited participation might work.

2.5 Conclusion

In this chapter I presented three approaches to participation: a participatory democracy, a human rights, and a PHC approach. I used these approaches to define participation in health as decision-making in health governance. I have presented a framework for participation, consisting of closed, invited and claimed spaces as useful to situate health committees as invited space. This frame is particularly useful in the context of this study, where citizens engage with the state both through formal health committee participation and in informal ways.

I have shown that the South African state has strong formal participatory features and structures and described the legislation that makes provision for health committees. I have highlighted two ways of forming participatory bodies, both in and outside the health system, namely through election or through appointment, with appointments being the preferred model in health. In exploring health committee participation, I have focused on research that measures decision-making and roles, arguing that participation often entails limited decision-making and roles. Additionally, I have used international experiences and experiences outside the health sector to illuminate invited spaces as complex spaces. I contended that there is contradictory evidence on how invited participation works and used this to reframe the question to ask: what form of invited participation may work and under what conditions?

Given that participation is about influence or control in decision-making that occurs between people in unequal power positions, power is a key factor in understanding invited participation. The next chapter will focus on reviewing the literature on power and present theoretical and conceptual understandings of power

3 Power: literature review and theoretical concepts

3.1 Introduction

This chapter presents a review of the literature on power and participation, followed by a description of theoretical and conceptual understandings of power. My thesis makes some core assumptions about power. Firstly, power in this thesis is considered to be multifaceted. It is not necessarily considered to reside in a specific actor, though it obviously can and sometimes does. Secondly, power may be exercised intentionally, but can also be expressed in non-intentional ways. It can be enacted consciously or subconsciously. In a similar vein, power is considered often to reside in structure, in dispositions, in the way we do things, in beliefs, in taken-for-granted assumptions that are not necessarily consciously articulated. The analysis therefore focuses more on the operation, manifestation and effect of power rather than on the intent. Another important assumption about power is that it can have both constraining and enabling properties in relation to agency. My interest in power is in relation to agency, to forms of power that constrain agency and forms of power that enable agency. To describe this, I use the terms 'constraining forms of power' and 'enabling forms of power'.

This chapter consists of four sections: a) an overview of the literature on power in participation; b) a section describing different forms of constraining power; c) a description of a theory on how dominant ideologies lead to the internalisation and sustaining of invisible forms of power; d) a presentation on a theory of resistance to power; e) a presentation of the concept of collaborative countervailing power; and e) an outline of enabling forms of power.

3.2 Limited attention to power in participation

Power is considered a central concept in participatory theory. Pateman (1970), for instance, considers equal power to be a crucial feature in decision-making. Head (2007) argues for the importance of recognising inequalities and power dynamics (2007). Cornwall and Coelho (2007) posit that power differentials between officials, health workers and other councillors in Brazilian health councils require that state actors relinquish some of their power in order for participation to work. The centrality of power in studying participation should also be understood with reference to participatory theory, which views participation as a form of

empowerment, and to those scholars who argue that participation should be viewed within an empowerment model (see, for instance Morgan, 1993).

Fung and Wright (2003a) are proponents of a specific type of deliberative democracy, which they call Empowered Participatory Governance, characterised by focusing on local problems, involving lay people and officials in finding solutions. This form of participation is characterised by being focused on local problems, involving lay people and officials, and using deliberation, where arguments based on what is reasonable and for the public good are supposed to lead to consensus decisions. While Fung and Wright identify Empowered Participatory Governance as a form of deliberative democracy, because it uses the method of deliberation, it obviously also incorporates aspects of participatory democratic theory in that it involves collaboration between lay people and officials. It is evident that health committees share important characteristics with this form of participation: they are local structures, they involve lay people and officials, and they deliberate in the sense that they debate issues. The arguments brought forward in their book can therefore be considered to have relevance for health committee research. Fung and Wright acknowledge that:

> Perhaps the most serious potential weakness of these experiments [referring to Empowered Participatory Governance] is that they may pay insufficient attention to the fact that participants in these processes usually face each other from unequal positions of power (Fung & Wright, 2003b:33).

Despite the acknowledgment of the importance of power, there has been limited attention to researching power dynamics in participatory processes, in particular in the health sector. An article which exemption is Scott and colleagues' 2017 paper (Scott et al., 2017), which examines power relations between members of village health committees in northern India and between community members an outside stakeholder. An important finding is that health committees can be considered invited spaces that are dominated by dominant actors. Further, they warn that at times there is a discourse of local responsibility, though some committee members contested this discourse and presented an alternative view of upstream responsibility. The paper is thus both a reminder of how powerful actors may control the discourse and how invited participation risk shifting responsibility from the state to local communities.

Similarly, a number of papers cite lack of power or authority over health facility staff and budgets as a reason why health facility committees were unable to exert effective influence (Loewenson, 2000; Kapiriri, Norheim & Heggenhougen, 2003; Loewenson et al., 2004).

However, these articles are exemptions. George and colleagues (2015a), in their review article on community participation in the health system, note that power/control is an under-researched area, which featured in only five of the articles reviewed. They conclude: "Future research should more thoroughly engage with community participation theory, recognise the power relations inherent in community participation" (George et al., 2015a:2). Furthermore, power was not the focus of the analysis in the five papers mentioned in George et al.'s article (Harman, 2009; Massa et al., 2009; Iwami & Petchey, 2002; Prata et al., 2012), but was mentioned only once, briefly and without much elaboration. Only one article focused on health facility committees (Goodman et al., 2011), but again power was mentioned only once and was peripheral to the overall content. Moreover, while power is mentioned in some articles, theories on power are not used extensively to understand how power operates. The same is the case in the South African literature on health committees: power is mentioned only peripherally without explaining how power operates.

George and colleagues warn that community mobilisation without attention to power relations can distort participation from its developmental aim and exacerbate existing patterns of exclusion (2015a: 2).

Power features more strongly in literature that focuses on the democratic potential of the invited space, such as Cornwall and Coelho's book (2007). The authors argue that the invited space is infused with power:

> These are spaces of power, in which forms of overt and tacit domination silence certain actors or keep them from entering at all (Gaventa, 2015). Yet these are also spaces of possibility, in which power takes a more productive and positive form: whether in enabling citizens to transgress positions as passive recipients and assert their rights or in contestations of 'governmentability' (Cornwall & Coelho, 2007:11).

Erasmus and Gilson's (2008) article on power in health policy makes some interesting points about power at South African health facilities. Though the topic of the article is not health

committees, the article's description of sources of power at play between health workers and community members is useful to think about in relation to health committee members as they are also community members engaging with health officials. Examples of sources of power include discursive 'labelling': "Being assigned the negative labels of 'being irresponsible' and of 'taking advantage' serves to de-legitimize patients, and to impede the rebalancing of power in the patient-provider relationship" (2008:363). These authors also suggest looking at sources of power such as 'the normal way of doing things', power derived from professional role, knowledge, personal characteristics such as charisma, links to networks and alliances to other powerful actors (2008:364).

3.3 Constraining forms of power: three faces of power and the Powercube

This section reflects on theoretical and conceptual understandings of power, where power operates as constraining agency, which is a widely held view of power. Constraining power may be observable, but it also takes non-observable forms. Lukes (1974) argues that power has three dimensions, which include both observable and non-observable expressions of power. Lukes acknowledges direct power as the first face of power but contends that it is important not to focus exclusively on observable power in decision-making. Rather, it is imperative to explore unobservable forms such as how some issues are organised into (politics), while other are organised out. He talks about non-decisions or non-events, referring to issues which never reach the decision-making arena, because actors are unsuccessful in their attempt to raise them. This aspect of power is labelled the second face of power.

> … it is crucially important to identify *potential issues* which nondecision-making prevents from being actual. In their view [referring to Bahrach and Baratz], therefore, 'important' or 'key' issues may be actual or, most probably, potential – a key issue being one that involves a genuine challenge to the resources of power or authority of those who currently dominate the process by which policy outputs in the system are determined (Lukes, 1974:19).

Furthermore, Lukes argues that not all power is observable. Rather, the most effective use of power is to prevent conflicts of interest from arising in the first place by getting people to accept their role or the status quo. The third face is invisible and internalised. Lukes (1974:24) asks the question:

> is it not the supreme and most insidious exercise of power to prevent people, to whatever degree, from having grievances by shaping their perceptions, cognitions and preferences in such a way that they accept their role in the existing order of things, either because they can see or imagine no alternatives to it, or because they see it as natural and unchangeable, or because they value it as divinely ordained and beneficial?

The *Powercube* is a conceptual tool for analysing power, developed by the Institute of Development Studies at Brighton University (Powercube, 2011). It has been used in many projects. The *Powercube* is partly designed to enable strategic interventions through understanding power. It is based on Lukes's work and the early work of John Gaventa from the Institute of Development Studies. The *Powercube* complements Lukes's framework by adding examples of how forms of powers are expressed and by adding two other dimensions to power: spaces and levels.

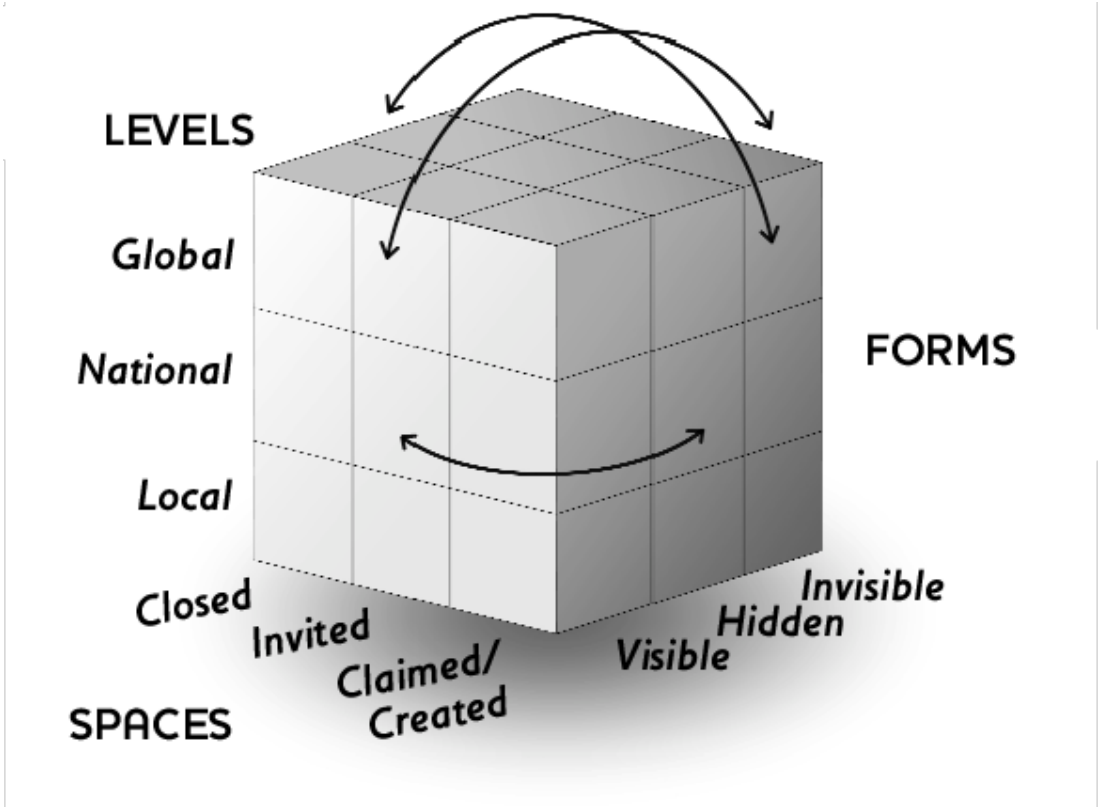

Figure 2: The Powercube (Gaventa, 2006:25).

The *Powercube* views the visible form of power as being linked to the decision-making field often in formal decision-making bodies. The visible form of power assumes that actors

(including powerless groups) can freely participate and articulate their views, and that by analysing who 'wins and who loses' one can understand who has power. Hidden power is similar to Lukes's second face of power in that it is concerned with a form of power that excludes views (and less powerful actors) from entering the decision-making arena. "This is done by dominant rules and procedures, the framing of issues in a way that devalues them, the use of threat of sanctions, and the discrediting of the legitimacy of actors who are challenging the status quo" (Powercube, 2011:11).

The invisible form of power is similar to Lukes's third face of power. It is different from hidden power in not being observable. In hidden power, actors attempt to exert influence but are prevented by constraining factors in the environment such as dominant rules or by being devalued. When invisible power is at play, actors do not attempt to exert influence. It is a form of power that prevents issues from being articulated because of internalised beliefs and values. "It involves the ways in which awareness of one's rights and interests are hidden through the adoption of dominating ideologies, values and forms of behaviour by relatively powerless groups themselves" (Powercube, 2011:12). Invisible power can be seen in members lacking confidence to speak, lacking knowledge and having certain beliefs that constrain them. The *Powercube* also conveys the idea of invisible power as 'internalisation of powerlessness' embedded in belief systems, values and understandings of how things work. For Gaventa, invisible power is seen as the subtlest form of power because it "shapes the psychological and ideological boundaries for participation… By influencing how individuals think about their place in the world this form of power shapes people's beliefs, sense of self and acceptance of the *status quo*" (Gaventa, 2006:29). While the invited space is participatory in nature, the *Powercube* authors argue that one has to analyse what goes on in the space, what the quality of participation is and what forms of power are exercised.

The second aspect of power in the *Powercube* is the different levels of power: the global, national and local (called sub-national). There is much debate about which level is most important. Increasingly, the global level is seen as an important level for both formal and informal participation. However, another argument suggests that national governments are still an important place for participation and engagement. An important question when analysing power across levels would be to ask where it is most effective to participate. For some advocates of participatory forms such as Fung and Wright (2003a), the local level is important. They associate participation with a shift of power from the state to local levels.

The dimensions of spaces (closed, invited, claimed) have been described in the previous chapter. The importance of these dimensions is to consider in which spaces actors have most power. Authors of the *Powercube* view expanding across levels and spaces as an important strategy to improve participation. However, as the topic for this thesis is participation at primary health care level, the main focus will be the forms of power within the invited space.

Both Lukes's view and the *Powercube* are useful in analysing power because they move away from a simplistic view of power as something easily observable.

3.4 Invisible power as internalisation of dominant discourses

While both the *Powercube* and Lukes posit that the invisible form of power is the most effective way for the powerful to remain in control, neither go into much detail about how invisible power operates. It is a commonly held view in the social sciences that power can be internalised, embedded and enculturated in actors, in beliefs, norms, taken-for-granted assumptions. Here, I focus on Haugaard's (2003) analysis of forms of power, which focuses on explaining *how* power becomes internalised. He outlines different processes through which power becomes internalised. Table 1 below illustrates these different forms of power.

Forms of power	*Example*
1. Power created by social order	Casual predictability created through reproduction of meaning; theorised as structuration and confirming-structuration.
2. Power created by system bias	Order precludes certain actions: destructuration.
3. Power created by systems of thoughts	Certain acts of structuration are incommensurable with particular interpretive horizons.
4. Power created by tacit knowledge	'Power over' based upon social knowledge that is not discursive. Empowerment through the transfer of knowledge from practical to discursive consciousness.
5. Power created by reification	Social order has to appear non-arbitrary.
6. Power created by discipline	Routine is used to make actors predictable through the inculcation of practical consciousness knowledge.
7. Coercion	Natural power as a base: violence and coercion as a substitute for the creation of social power.

Table 1 Haugaard: Forms of Power (2003:23).

Haugaard presents a typology of seven forms of power creation, which in his own words allows for "diverse phenomena from previously divergent perspectives to be woven into a theoretical whole which renders them commensurable" (Haugaard, 2003:87). The first form of power creation builds on Giddens's (1984) structuration theory, but with the important difference that Haugaard suggests that reproduction of social order does not just take place through structuration, but presupposes that other actors recognise and confirm the

structuration of the social order. Haugaard calls this action 'confirming-structuration'. Through confirming-structuration, shared meaning is reproduced, and consensus is built.

The second form of power is created by what Haugaard calls bias and occurs through the imposition of structural constraint by one actor upon another (2003:94). This form of power creation occurs when an actor, instead of 'confirming-structuration', destructures or 'non-confirm-structures' new structuration practices. This form of 'destructuration' will often occur to sustain the status quo of existing power relations. Haugaard links destructuration to non-decision-making and non-issues, referring to issues that are left out because they are not deemed relevant for the powerful actors who have the ability to 'destructure'. "When a non-issue is raised and directed at those in power, they will claim an inability to confirm-structure because that is not 'how things are done'" (2003:95). Social change, on the other hand, occurs when new consensus is built through novel structuration practices that are being confirmed. An important point about this form of power is that active destructuration does not always take place. Rather, "most socially competent actors know what type of structuration practices are likely to be destructured and, as a consequence, do not put themselves in situations of attempting to reproduce structures which others are likely to consider inappropriate" (2003:95). Thus, silence and not raising issues could be linked to this form of power.

The third form of power is linked to what Haugaard calls interpretive horizons or systems of thoughts. This relates to how people make sense of the world and interpret it. In relation to structuration, actors will only confirm certain structurations if they are in line with their own interpretive horizon. "If a new meaning is not consonant with the current interpretative horizon, destructuration will take place; hence, powerlessness will be reproduced with respect to the issue" (2003:98).

Haugaard's fourth form of power relates to Giddens's practical and discursive consciousness. The author argues that most confirming-structuration occurs as a result of tacit knowledge or practical consciousness. Because this happens at a non-discursive level, actors 'confirm' structure almost by reflex (2003:101).

Reification of interpretive horizons represents a fifth form of power. Reification basically stabilises structures by making them appear to be more than social constructs. While

reification in the past often relied on a belief that something was ordained by God, or was part of the natural order of things, Haugaard argues that scientific 'truth' serves the function of reification in modernity. On that note, Haugaard argues that Foucault's social critique should be viewed as a form of de-reification because it shows "that things are not as self-evident as once believed" (2003:103).

Discipline is the sixth form of power. Here Haugaard draws on Foucault. Discipline involves the internalisation of certain interpretive horizons, which then ensures that the 'disciplined actor' acts in a predictable manner in confirming-structuration. "Disciplinary power is particular to modernity and is an outcome of the transformation of interpretative horizon which includes the idea that it is possible to shape socialization to a standardized mould" (2003:106). In disciplined actors, embedded norms may cause people to discipline themselves, not needing external forces to do so. The final form of power creation is coercion, which Haugaard views as a physical form of power. Coercion occurs when social power does not work – when the confirming-structuration does not take place.

An important aspect of Haugaard's theory – which he shares with many social theorists – is his view of agency. For Haugaard, converting tacit knowledge to discursive knowledge can enable actors to evaluate and challenge certain structures and interpretive horizons. "While knowledge remains merely tacit, it is not confrontable but once rendered discursive, it becomes something which we can distance ourselves from, recognize and evaluate" (2003:102).

Like Haugaard, theorists who view power as internalisation of dominant ideologies do imagine agency to be possible through reflexivity or becoming aware of constraining beliefs and dominant ideologies. This occurs through the transfer of practical to discursive consciousness. For instance, implicit in the *Powercube* is the assumption that an analysis of power will result in a better understanding that can be used to design strategies to mitigate power.

The importance of Haugaard's theory of power is that it provides an understanding of the processes that lead to beliefs, assumptions, taken-for-granted ideas, which become enculturated and seem natural and reified. At the same time, his theory provides an understanding of how 'uncovering' these processes can facilitate agency.

3.5 Power and resistance: hidden and public transcripts as a reaction to domination

The previous section presented an argument for understanding invisible power as the internalisation of dominant ideologies. James Scott's work on power and resistance challenges this understanding (Scott, 1990). The author presents an alternative to these theories. Scott suggests that power – or domination – generates a public transcript and a hidden transcript rather than leading to internalisation. He argues that powerless groups have an interest in presenting hegemonic appearances in the public sphere, but this does not mean that they believe in hegemonic discourses.[13] Rather, presenting a public transcript in words and actions is a strategic choice made by people fully aware of their domination. Scott's theory posits that overt domination or lack of belief in alternatives may lead actors to 'perform' the public transcript. This does not mean that they have internalised, naturalised or reified it – as Haugaard's understanding of power would suggest – but rather that the public transcript is a performance. Alongside the public transcript is a hidden transcript, a transcript of resistance, created in a social space to which the powerful do not have access. According to Scott, the hidden transcript talks against the public transcript in a subtle way that shies away from direct confrontation. The hidden transcript is a form of resistance that takes many forms. The hidden transcript "confirms, contradicts, or inflects what appears in the public transcript" (Scott, 1990:4-5).

Scott's theory presents both a theoretical and a methodological challenge. He challenges the theory that dominant discourses become internalised and as such act as a form of invisible power. Methodologically, he posits that social scientists have often focused on describing dominant ideologies or hegemonies, because they only have accessed the public sphere and are oblivious to it being a performance. Similarly, they have been unaware of the existence of a hidden transcript. In that sense, Scott challenges us to consider data differently. He argues that the public transcript:

> provides convincing evidence for the hegemony of dominant values, for the hegemony of dominant discourse... any analysis based exclusively on the public transcript is likely to

[13] Scott uses the concepts of 'ideologies' and 'hegemonies' interchangeably despite their different meanings in the theoretical literature.

> conclude that subordinate groups endorse the terms of their subordination and are willing, even enthusiastic, partners in that subordination (1990:4).

Scott argues against viewing the public discourse as a confirmation of dominant discourses. He does so by arguing against the theory of false consciousness both in what he calls its 'thick' form and its 'thin' form. The 'thick' form refers to false consciousness as consent, whereas the 'thin' form refers to a form of consciousness where subordinate groups understand the social order as natural and inevitable and therefore are compliant, but do not perceive the order to be just. Furthermore, Scott suggests that past experiences may lead to resignation. Thus, there are many reasons for compliance other than internalisation of dominant ideologies.

> By persuading underclasses that their position, their life-chances, their tribulations are unalterable and inevitable, such a limited hegemony can produce the behavioural results of consent without necessarily changing people's values (1990:74).

Scott rejects both the 'thin' and the 'thick' forms of hegemony. His main argument is that it is difficult to explain how social change would ever occur if hegemony had the kind of stronghold as suggested by theories on hegemony. He provides historical evidence to suggest that the opposite is in fact true: that rather than accepting dominance, people often exaggerate their own power and the possibility of emancipation. Arguing against Gramsci's understanding of hegemony, Scott suggests that it is not ideology that is constraining.

> Other things being equal, it is therefore more accurate to consider subordinate classes *less* constrained at the level of thought and ideology, since they can in secluded settings speak with comparative safety, and *more* constrained at the level of political action and struggle, where the daily exercise of power sharply limits the options available to them (1990:91).

Importantly, Scott suggests that there are situations in which domination/power persists through hegemony, namely where people are 'atomised' or where individuals have an expectation that they will eventually exercise domination over others. The concept of 'atomisation' refers to situations where individuals are isolated geographically or otherwise. This atomisation means that there is no social space in which the hidden transcript can be created.

Moreover, Scott seems to indirectly acknowledge the possibility that certain actors may respond with internalisation, while others do not. This raises the question of whether there are different ways of responding to dominant ideologies, a question Scott does not address directly. The first is through internalisation and self-discipline. The second through resistance carried out in a hidden transcript, while performing a public transcript.

Scott's view of change differs from that of theorists such as Haugaard. He argues that change occurs when the hidden transcript breaks through to the public arena. The offstage utterances of the hidden transcript act as a preparation for speaking in the public arena. They test the possibility of speaking the hidden transcript in the public sphere. He refutes the view that the hidden transcript can be seen as an arena where tensions can be let out. Rather, he suggests that the hidden transcript constantly pushes against the public transcript in preparation for entering the public domain. When this happens, dominance and power are challenged. "*It would be more accurate, in short, to think of the hidden transcript as a condition of practical resistance rather than a substitute for it*" (1990:191) (Scott's italics) and further "under the appropriate conditions, the accumulations of petty acts can, rather like snowflakes on a steep mountain side, set off an avalanche" (1990:192).

It is important to bear in mind that Scott's work is largely based on societies where the powerless were not citizens. His historical analysis is based on societies where there was one dominant and one subordinate class, (as opposed to more complicated/stratified societies). Historically, apartheid-South Africa was a society with a dominant and subordinate classes, in which the majority did not have citizenship and political rights. However, in current day South Africa citizenship and political rights are shared amongst all members of society. Nevertheless, I argue that his theory is relevant for the following reasons. Firstly, while formal political power is now in the hands of all citizens, economic and social power is still unequally distributed. Secondly, adult South Africans grew up during apartheid and – as noted for instance by Cornwall and Coelho (2007) and Williams (2007a) – an authoritarian system and political culture leaves a legacy. These experiences will also have left a legacy in terms of how people view their place in the world.

Scott's theory is useful to consider for the following reasons. 1) It serves as a reminder to look beyond the observable to 'hidden' layers that may more accurately reflect people's

experiences and thoughts; 2) it challenges the notion of internalised power and suggests an alternative understanding; and 3) it provides an alternative view of how agency operates, and social change occurs. These are all important in the context of health committee participation, which takes place in a context of unequal power relations. Exploring different ways in which health committees experience and respond to power adds to a deeper understanding.

3.6 Countervailing collaborative power

An important contribution to power in participation comes from Fung and Wright's book *Deepening democracy. Institutional innovations in empowered participatory governance* (2003a). They argue that many proponents of participatory collaboration have ignored the asymmetrical power relations and that inequalities in power can subvert the democratic potential. The authors focus their attention on power and participation in what they call Empowered Participatory Governance (Fung & Wright, 2003a).

Fung and Wright's main argument is that participation without a more equal distribution of power is likely to fail. In the concluding chapter they introduce a concept called countervailing power.

> Our discussion will revolve around the concept and role of what we term *countervailing power* – a variety of mechanisms that reduce, and perhaps even neutralize, the power-advantages of ordinarily powerful actors. We contend that in nearly all contexts significant countervailing power is necessary for EPG [Empowered Participatory Governance] to yield the benefits for democratic governance that we have claimed for it (2003c:260).

Countervailing power is a concept that describes how actors that normally have less social power can challenge more traditional powerholders. Forms of countervailing power are well-known in what Fung and Wright call adversarial arenas, such as where social movements or civic groups challenge the more established centres of power. They call this adversarial countervailing power. In South Africa the prime example would be the anti-apartheid movement, and more recently related to the health system, the TAC. The TAC is also a useful

example of some of the means social movements use as adversarial countervailing power, namely mass mobilisation and litigation.[14]

Fung and Wright distinguish between different models of governance, characterised by two features. Firstly, there are adversarial and collaborative forms of decision-making. Secondly, there are top-down and participatory types of decision-making. Combining these different aspects results in four different types of governance structures and processes as illustrated in Figure 3 below.

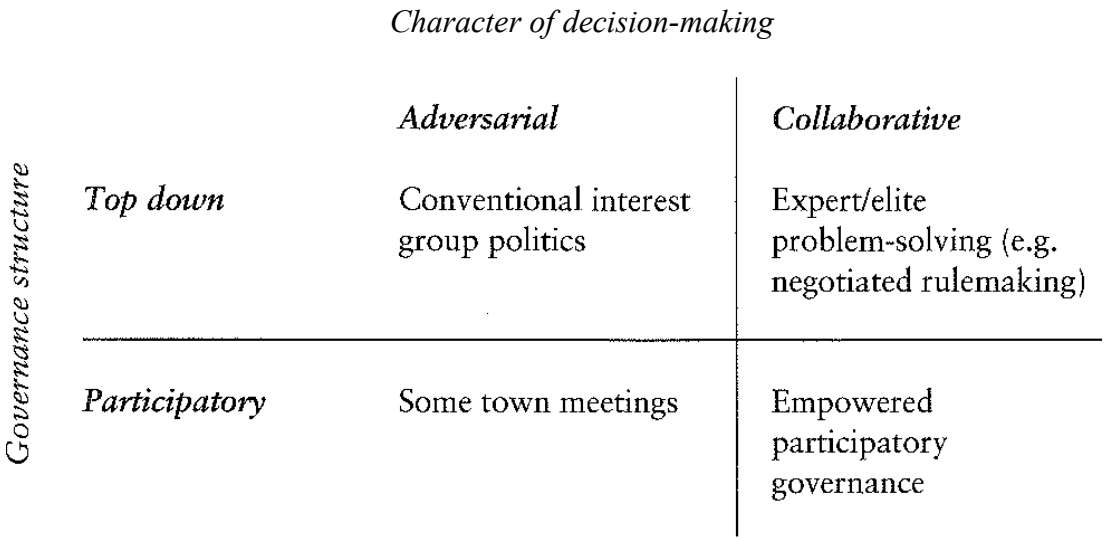

Figure 3: Varieties of governance structures and processes (Fung & Wright, 2003c:262).

Critiquing top-down governance for often generating solutions that lack relevance because they are not informed by local knowledge, Fung and Wright propose that collaborative governance is an alternative to adversarial interest-group politics (2003c:262). However, the potential of participatory forms of governance, according to Fung and Wright, is related to how much countervailing power those collaborating with traditional power-holders have. Participation without countervailing power is likely to favour those previously organised or concentrated interests (2003c:263). In other words: "We believe that, in general,

[14] The TAC can be considered both an adversarial and a collaborative structure – working both in opposition to and in collaboration with the state.

collaborative governance without an appropriate form of countervailing power is likely to fail…" (2003c:263). A challenge for collaborative participatory structures is that when countervailing power is already organised in an adversarial form, these actors are likely to oppose a movement towards a more collaborative form of governance. Those already organised around adversarial forms of power will be better able to advance their interests than those who do not possess (collaborative) countervailing power.

Considering the degree of countervailing power in relation to top-down administration and participatory collaboration, Figure 4 below captures four governance regimes. It is evident from this that Empowered Participatory Governance and other forms of participation require both collaboration and a high degree of countervailing power.

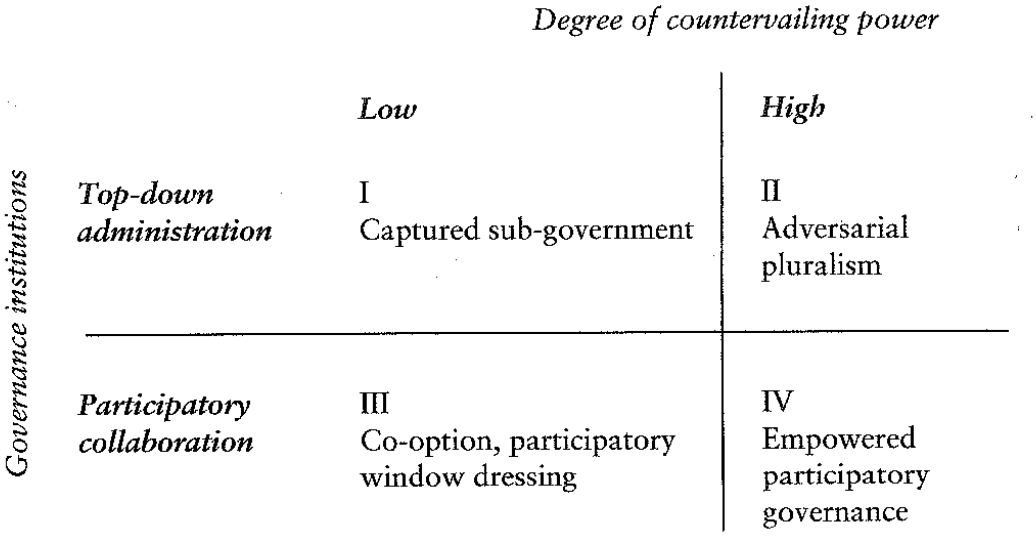

Figure 4: Four governance regimes (Fung & Wright, 2003c:265).

In the absence of countervailing power, participation can in practice amount to state-shrinking or to participation becoming window-dressing. Without countervailing power traditional powerholders can engage in participation without surrendering too much control.

> When collaborative reforms aim to open service agencies – schools or police departments – to broader participation, street-level bureaucrats who are trained, full-time professionals can protect their prerogatives even as they ostensibly collaborate with parents, residents, and other lay participants. For these reasons, therefore, we feel that robust, democracy-enhancing

> collaboration is unlikely to emerge and be sustained in the absence of effective countervailing power (2003c:264).

Fung and Wright argue that because scholars have mainly been interested in social movements of 'protest and disruption', there has been limited interest in collaborative participatory forms of engagement and "there are few conclusive findings regarding the operations, outcomes, or even prevalence of this emergent governance mode" (2003c:285.) Others reject participatory collaborative governance because they find that it is difficult to construct or locate countervailing power (2003c:286). In fact, collaboration (in particular deliberation) may seem at odds with the idea of countervailing power, according to Fung and Wright: "What, precisely, does it mean to talk about mobilized forms of power of disadvantaged groups in a decision-making setting that is meant to engender collaborative, deliberative problem-solving?" (2003c:260).

Though Fung and Wright argue for collaborative participatory forms of engagements, they are not oblivious to the achievements gained through adversarial tactics. Rather, they concede that adversarial and collaborative engagement can contribute to similar goals. They posit that often adversarial tactics are useful at a policy and national level, but that collaborative tactics can be more useful at practice level. An illustrative example of this is achievements in anti-discrimination in the workplace through top-down adversarial pressure. However, they argue that there are limits to what top-down adversarial strategies can achieve. For instance, they argue that subtler forms of discrimination can better be addressed through collaborative participation, where those at the receiving end have the contextual knowledge to address these issues and transform organisations.

Given that adversarial forms of engagement possess countervailing power, the authors ask if adversarial countervailing power can be transferred to collaborative countervailing power. However, the answer in the negative because of three barriers. Firstly, it is a case of a mismatch of scale: adversarial structures generally operate at a centralised scale, whereas collaborative forms operate at a more local scale. Secondly, they argue that different skill sets and competencies are required in adversarial and collaborative forums. Adversarial organisations use strategies of communication, information provision, persuasion and mobilisation, whereas collaborative participation requires competencies in problem-solving and implementation. Thirdly, adversarial social movements – according to Fung and Wright

– draw on shared understandings and cognitive frames such as the 'injustice frame' that is used to generate a common purpose and calls for action - a similar concept to Barnes (2007) 'oppositional consciousness', which she argues social movements draw on. According to Fung and Wright, shifting these cognitive frames requires shifting mental frames and this is not likely to happen. They argue that many social movements employ mental frames that "do not lend themselves to collaborative problem-solving approaches" (2003c:282). For adversarial countervailing power to be transferred to collaborative countervailing power, these cognitive frames would have to be transformed. This goes to the very core of the identity of these organisations. While Fung and Wright are pessimistic with regards to collaborative forums acquiring countervailing power from adversarial ones, they concede that locally rooted organisations can more easily shift their mental frames than their national counterparts can. They provide examples of local organisations that have developed frames that draw both on adversarial and collaborative understandings and have been able to generate countervailing power that can be used in collaboration.

A pertinent question for collaborative participation is then: what are their potential sources of collaborative countervailing power? There is limited evidence as there has been limited attention to these issues, but the authors suggest possible sources. Two common sources of countervailing power for participatory collaboration can come from policies and from political leaders who view participation favourably. Examples of this are political parties in Brazil's Porto Alegre state and India's Kerala state, two of the four case studies in Fung and Wright's book (2003a). The third path for generating collaborative participatory countervailing power is considered to be slow transformation of local adversarial countervailing power.

> Countervailing sources of power usually arise from the policy, outside the boundaries of the institutions themselves, and their presence is contingent upon capricious factors such as those that give rise to interest groups, social movements, and lower barriers to collective action generally (2003c:267).

Furthermore, they suggest that local collaborative participation initiatives are likely to arise where there is already substantial local countervailing power (adversarial). Examples of countervailing power are parent organisations and environmental groups, social movement organisations, professional groups etc. Referring to school participatory reforms, Fung and

Wright argue that "well-organized parents and community-based countervailing power can operate through different paths and grow from different origins to sustain participatory collaboration in educational governance" (2003c:278). This raises the question of whether well-organised communities or patients could provide community-based countervailing power to health committees.

Overall, Fung and Wright's approach is useful to answer questions about whether health committees have countervailing power, and if so, what is the source of this power? If countervailing power is absent, what are the reasons and what are potential sources of acquiring it? The question of whether collaborative countervailing power can come from adversarial structures is also relevant to consider in this context, where collaborative health committee participation exists alongside more adversarial forms of engagement.

Countervailing power can be viewed as a form of power that enables participation. In the main, the sources of countervailing power come from externals sources such as a policy, politicians and organised communities. But for participation to work, participants also need agency. Considering where they might get that from will be the focus of the following section on enabling power.

3.7 Enabling power

A complementary view of power is presented by VeneKlasen and Miller (2007), whose understanding adds another dimension to understanding power by focusing on three forms of power that result in agency. This view of power is also relevant because it takes the *Powercube*'s three forms of power as its starting point for presenting a framework that looks at forms of power that enable agency. VeneKlasen and Miller present the following forms of enabling powers: 'power with', 'power within' and 'power to'. These are contrasted with 'power over', which is a term used to encapsulate the constraining aspects of power described in the *Powercube*. 'Power with' is basically a power derived from collective strength and collaboration, based on finding common ground. 'Power to' "refers to the unique potential of every person to shape his or her life and world" (VeneKlasen & Miller, 2007:45). When combined with the 'power with' dimension, it can result in agency. 'Power within' is linked to people's self-worth and self-knowledge. It is linked to their capacity for agency. Aspects of enabling power that are mentioned in VeneKlasen and Miller's framework include

knowledge and collectivity. While the framework is not very elaborate or explanatory in defining sources of power, its approach serves as an important reminder to look for sources of power that enable actors' agency. It is useful as a starting point for asking where enabling power/agency comes from. Is it a result of resistance being transferred from a hidden to a public arena, or is it a result of a form of tacit knowledge becoming discursive? Does it come from the sources suggested by VeneKlasen and Miller, or from other sources? The framework thus adds an important dimension to the framework that views power as constraining.

An important question to consider is whether these forms of enabling power can be considered to be countervailing power. If Fung and Wright's definition of countervailing power as mechanisms that neutralise or minimise power differentials between the less powerful and traditional powerholders is taken as a starting point, then they should be considered forms of countervailing power. However, there is also a difference between the sources Fung and Wright list as countervailing power and the sources described by VeneKlasen and Miller. Countervailing power is derived from external sources: it comes from legislation, politicians, organised communities. It provides a mandate or a right to participate and obliges traditional powerholders to engage in collaborative participation. Countervailing power would ensure that health committee members can operate in the participatory sphere and that the health system will engage with them.

The sources presented by VeneKlasen and Miller are mostly internal sources which enable participants' agency. These forms of enabling powers – such as beliefs, knowledge and confidence – are necessary for participants to be able to engage in participation because they are prerequisites for agency. My understanding, thus, is that there are two forms of power necessary in participation: countervailing power and enabling power. Enabling forms of power are necessary for participants' agency but may be insufficient if they do not have countervailing power. Countervailing power, on the other hand, may not lead to effective participation in the absence of enabling powers. Neither countervailing power nor enabling power are sufficient in themselves, but both forms are necessary.

3.8 Conclusion

This chapter has provided a number of theoretical and conceptual understandings of power. Firstly, I outlined three forms of constraining power: visible, invisible, hidden. Secondly, I described how power becomes internalised and enculturated in actors through processes of confirm-structuration, bias, systems of thoughts, tacit knowledge and reification. Thirdly, I provided an alternative understanding of power to the view that hegemonic discourses become internalised. It proposes that instead of internalising beliefs, people create public and hidden scripts, which can be a form of resistance. I then described the concept of countervailing power necessary to counterbalance the power of traditional powerholders. The theory of countervailing power explores where actors in participatory forums get power from. Fifth, I argued that participants may also draw on enabling forms of power. I argued that both external countervailing power and power that enable agency are necessary in participation.

Linked to these understandings of power are also different views on agency. The first posits that agency occurs through transforming tacit knowledge to discursive knowledge or through 'uncovering' the constraining belief systems. The second suggests that agency becomes possible through rehearsing resistance in hidden spaces and testing this resistance before it is transposed into the public sphere. The third view of agency is linked to people's understanding of themselves and collective agency.

4 Methodology

4.1 Introduction

The methodology chapter covers the following topics: a justification for the chosen study design, a description of the study sites and the health committees involved in the study. This is followed by a description of data-collection methods and the data-analysis approach. A section on research rigour precedes the ethical considerations. The procedures for ensuring informed consent are described in the last section.

4.2 Study design: qualitative multiple case study

The research question focus on understanding how different forms of power impact on invited participation. The previous chapter outlined a number of theories of power. Together, these theories suggest that understanding power is complex and that power is sometimes observable, sometimes invisible and internalised as dominant ideologies, beliefs, behaviours, understandings and taken-for-granted assumptions. Power may also result in the creation of a hidden script. The research question and the complex context necessitate an in-depth study and a study design that includes observations of participants' actions rather than just relying on oral data in order to be able to observe hidden transcripts and invisible forms of power.

I chose a qualitative case study design because it enabled me to observe the real-life context of health committee participation and their engagement with communities and the health services over a period of time and so to explore the impact of different forms of power. A case study allows for research that incorporates a holistic set of methods, rather than relying on a single or few qualitative methods such as interviews or focus groups. Case studies are characterised by using several methods for data collection, including observations, which are important because oral and written data – what participants say or write – do not necessarily reflect what they do or what happens in practice. As noted by Yin (2014:16), "a case study is an empirical inquiry that investigates a contemporary phenomenon (the 'case') in depth and within its real-world context".

The reason for choosing qualitative data-collection methods such as observations, in-depth interviews and focus groups is that these are most suitable to capture complex issues such as how participation takes place and how forms of power are expressed and experienced.

Furthermore, this case study is based on prolonged engagement with study participants, which is more likely to allow sufficient time to understand context and the complexity inherent in the study. Prolonged engagement also guards against early closure and builds trust between researcher and study participants and this can facilitate sharing of experiences, beliefs and understandings that may not have surfaced through short-term engagement.

In choosing how many cases to incorporate in the study, consideration was given to the need to do in-depth inquiry (quality) weighed against the potential benefits of doing a multiple case study. As noted by Yin (2014), a multiple case study design has an advantage over a single case study in its ability to compare findings. These considerations led to the choice of a multiple case study with two health committees. Having two cases allowed the benefits of multiple case studies such as comparison, while limiting the study to two cases ensured sufficient in-depth investigation.

The two committees were chosen purposefully to explore different contexts as they reflect contrasting and diverse experiences. As Yin (2014:64) notes, if findings from contrasting sites support each other, such a case study design offers a strong case for theoretical replication. Hence, one case was situated in an urban area, the other in a rural area. The choice of a rural and an urban committee offered opportunity to examine the impact of context as well as explore alternative, contrasting processes for participation.[15]

While I had extensive knowledge of urban health committees prior to the research, this was not the case for rural health committees. A process of identifying functional rural health committees in the Western Cape Province preceded the research and confirmed an assumption that functional health committees in rural areas of the province are rare. Moreover, as described in Chapter 2, very little is known about health committee participation in rural South Africa. In addition to the two cases, the study also followed the broader developments around health committee participation, in particular as it pertained to the promulgation and implementation of the *Western Cape Health Facility Boards and Committees Act 2016* (2016).

[15] A case study with two cases can be called a multiple or a dual case study. I follow Yin in using the term multiple case study.

The methods were employed flexibly, which allowed me to adopt methods during the course of fieldwork. For instance, I found that focus groups yielded far more data than interviews. Furthermore, as the Act on health committees was promulgated just as the research started and implementation began during the research period, the research was adapted to explore this new element. The flexible design also allowed me to include theoretical sampling and identify participants during the course of the research. In theoretical sampling research participants are chosen purposefully in order to develop theory, concepts, comparisons or explore relationships. Theoretical sampling is made possible through the iterative process of data collection and data analysis. Sampling is driven by the development of ideas and concepts and takes advantage of fortuitous events (Corbin & Strauss, 2008:145). For instance, important community-based organisations such as the TAC and the regional South African Communist Party (SACP) as well as the so-called Upper Structure chairperson were included in the research as the proved to be important actors. The Upper Structure is an umbrella body for health committees in the urban sub-district also called the Health Forum. Many fortuitous events contributed significantly to the analysis, including meetings between the Department and communities about the Act.

Theoretical sampling is linked to the concept of saturation, which is the point where all concepts are well-developed and explained, and no new data emerge. The analytical process is explained by Corbin and Strauss:

> Analysis begins after the first day of data gathering. Data collection leads to analysis. Analysis leads to concepts. Concepts generate questions. Questions lead to more data collection so that the researcher might learn more about those concepts. This circular process continues until the research reaches the point of saturation; that is, the point in the research when all the concepts are well defined and explained (2008:144-145).

My focus for this study was health committees. In the cause of the fieldwork, I came into contact with other key informants. In some cases, I chose to interview them. This included both facility managers. I also attended many meetings where other health managers attended and articulated their views. While health managers could have provided a valuable source of information, I did not include interviews with them as the scope and scale of this study did not allow this.

4.3 Study sites

The urban site is situated in a typical South African township on the outskirts of Cape Town, consisting of both formal and informal housing. The population is mostly isiXhosa speaking. Many residents in the area hail from the rural Eastern Cape Province and often migrate back and forth between the Eastern Cape and Cape Town. The area is an economically depressed area with many economic, social and health challenges, including high rates of TB and HIV. The health committee in this area was a well-established committee with links to the Cape Metro Healthcare Forum (CMHF). Furthermore, the urban committee has been part of a capacity-building programme carried out by the Learning Network on Health and Human Rights (LN) between 2013 and 2015, training that was generally assessed to be effective (Haricharan, 2015b). The Learning Network is a collaboration of academics and civil society organisations founded in 2008 with the aim of exploring civil society's role in realizing the right to health.

The rural site is situated approximately 150 kilometres from Cape Town in a farming area. The population is predominantly Coloured,[16] but there is also a relatively large African population as well as a White population, though users of the local public clinic were in the main the Coloured and African population. The town and the surrounding farming area are more socially and economically diverse than the urban site is. Similar health challenges face the population as in the urban area, in particular the sections of the population that use the local clinic, namely the lower socio-economic strata. The town is, like all South African towns, still residentially segregated along racial lines as it was during apartheid. About 80 percent of the South African population use public health care, the rest private health care. Health committees pertain only to public facility and the absence of Whites is likely to reflect the fact that the wealthier part of the population make use of private facilities.

Health committee members in both sites generally belong to lower socio-economic groups and had limited education. Only one urban health committee member had a post-high school

[16] Racial classifications such as African, Coloureds and Whites are terms used to categorise people during apartheid. They are widely used in current South Africa, and I therefore also use them in this thesis, despite not subscribing to the use of these terms. These terms are significant in describing the settings for the study as South Africa remains a racially divided society with the legacy of the apartheid system being reflected in many aspects of society.

diploma, three had passed high school, while the remaining five had no formal school-leaving qualification. In the rural committee, one member had a teacher's diploma, one had finished high school while the rest had no school leaving qualification. In the urban committee all but two were unemployed at the start of the research period. One member practiced as a traditional healer, another was a student. In the rural committee there was a retired school principal, an unemployed former farmworker and four members working in low-paying jobs as farmworkers or cleaners. All health committee members besides the retired principal had a household income below ZAR 30.000 annually (approximately US Dollars:2080).

When fieldwork started in August 2016, both the urban and the rural health committee had been in existence for about 1½ years. For the urban committee, a constitution outlined their terms of office. As the rural committee did not have a constitution, its terms of office were not determined.

The urban committee was far more active than the rural one, with regular meetings with or without the facility manager. It also met regularly to collect patients' complaints. There was no schedule for meetings and they seemed mostly to take place in an ad hoc fashion. The committee used a WhatsApp group to communicate and members or the facility manager would take initiative to call a meeting. If urgent issues needed to be attended to, meetings would also be called. In addition, members of the committee spent time at the clinic to monitor service delivery. At times groups or individuals would approach the facility manager, who had an open-door policy, with issues they had encountered. The rural committee was not nearly as active as the urban one and struggled to maintain regular meetings. In particular, they struggled to organise meetings with the facility manager. Some members would go to the clinic to address issues, but they were not involved in complaints management like the urban committee. Because of the urban committee being more active, there were more opportunities for material and data to emerge in the urban committee. Hence, there is a stronger focus on the urban committee in the thesis.

4.4 Data-collection methods

Case studies rely on a number of different data sources and the use of and purpose of different data sources will be explained in this section. Since the research question also relates to policies, an analysis of policies forms a central part of the case study. This analysis

relates primarily to the *Western Cape Health Facility Boards and Committees Act, 2016* (2016), but also reflects on other policies described in Chapter 2.

I reviewed available documents such as health committees' constitutions, agendas and minutes of health committee meetings. However, only the urban health committee had these documents and even here documents were not consistent and up-to-date. The rural committee said it had kept minutes, but these were lost. I conducted two surveys with health committee members, one on demographical data, and one gathering data on organisational and political experiences.

Observations were an important method and was ongoing. It consisted of observing health committees in all their activities – health committee meetings, other meetings and complaints management. Where relevant and possible, I also observed daily life in the communities and at the clinic. The purpose of observations was to observe the real-life context, observe relationships, behaviours, interactions, actions and discussions rather than relying solely on oral/written data. Furthermore, observations were extended to the broader health committee context including meetings with the provincial Department of Health around the creation and implementation of the Act and other meetings organised by the Department, the health sub-district or other stakeholders. Observations were 'open' in the sense that I did not have a framework looking for specific aspects, but having theoretical frameworks meant that my observations were tuned towards looking for different transcripts and expressions of power.

While observations mainly occurred around organised activities such as meetings, they also involved spending time with health committee members and other stakeholders. This mostly occurred when meetings were cancelled or while waiting for activities to commence. Informal interactions added to my understanding of the research context, in particular participants' socio-economic context. Constraints they faced both in their daily lives and with regards to health committee participation came to the surface.

Focus groups with health committees were an important data-collection method. These were ongoing throughout the research period and covered a variety of topics. Some topics were revisited several times during the research period to get a more in-depth understanding and to explore how and if views, beliefs and understandings changed. I attempted to start with very open-ended questions. This was to ensure that participants' voices and opinions were

expressed freely. While I also did in-depth interviews with health committee members, focus groups yielded much more complex and in-depth data because issues emerged when health committee members responded to each other and discussed issues. In addition, focus groups provided interesting data of what can be articulated amongst health committee members, but not in health committee meetings, where the facility managers were present, thus shedding light on hidden or public transcripts.

Towards the end of the research period, a number of focus groups with health committees were held to probe previous findings and emerging themes as well as to do member checking. A final focus group explored participants' experiences of being part of the research project.

Interviews were conducted with health committee members, facility managers, community members and other stakeholders. They were conversational and open, although based on topic guides.

Data collection and preliminary analysis was done concurrently in an iterative process. The reason for this was to allow data collection to be informed by preliminary analysis of already-collected data. On-going comparisons between observations and oral data aided in the data analysis. All interviews, focus groups and meetings were recorded and field notes were taken for all data-collection methods. This enabled me to use collected data for continued reflection and to use data to inform and guide further data collection.

For instance, observations were used as an important source for formulating topics and questions for interviews and focus groups, as this ensured that these were rooted in the real-life context. Topic guides for focus groups and interview guides for interviews were thus based on the research questions and theoretical and conceptual frameworks as well as on questions generated through preliminary readings and analysis of collected data. An example of a topic guide is attached as Appendix B.

As I do not speak isiXhosa or Afrikaans, the languages most commonly spoken in the urban and rural site, respectively, translators were used with participants who preferred to communicate in their mother tongue. I employed two translators from the communities. In the urban site I employed a health committee member from another health committee; in the rural site I employed a community activist. The choice of translators from the community

meant that they were familiar with the settings and the context. However, at times it also meant that they had an interest in the discussions and I had to attempt to ensure that participants did not confuse their role as translators with their role as engaged community activists by asking them not to comment when they translated. Yet there were occasions where they insisted on commenting. In those cases, I stressed that they were doing so in their personal capacity, not as translators.

The duration of the field work was almost two years from the first contact with the health committees until data collection ended, although data collection during the last six months was less intense. I kept in touch with the committees to follow the implementation of the Act.

By the time data collection ended, most concepts were theoretically saturated. For instance, no new understandings of how power influenced participation emerged and the factors that impacted on participants' decisions about which spaces to participate in were understood. However, as the Act had not been implemented, it is impossible to say if new events will emerge that impact on their decision-making.

4.5 Data analysis

The data were analysed using both inductive and deductive methods. First, I did an initial inductive coding, followed by a deductive approach. This section will provide an argument for using both inductive and deductive methods and then outline the analytical approach.

Jackson and Mazzei (2012) criticise in their book *Thinking with theory in qualitative research. Viewing data across multiple perspectives* much qualitative research for not using theories to explain findings, but rather rely on coding data. They contend that coding data does not capture the complexity of social life but produce knowledge within a closed system. Jackson and Mazzei are critical of research where statements are taken at face value and 'voices' are expected to speak for themselves. They argue that this form of research view data free of circumstances and context and treat 'voices' as if they reflect 'the truth' as normative and containable data. The authors argue that simply coding data is insufficient to explain the phenomenon studied. On the other hand, the authors are critical of approaches that use a single theory to interpret data as they view this as being too constraining and simplistic.

Jackson and Mazzei's approach to qualitative data analysis is described as using multiple theoretical perspectives to analyse data or 'plugging into' a specific theory to explore what the theory could add to the interpretation. The authors posit that through this, knowledge is opened up. "The result of 'thinking with theory" across the data illustrates how knowledge is opened up and proliferated rather than foreclosed and simplified" (Jackson & Mazzei, 2012: vii). In the process, it is suggested that a particular theory is used to 'ask questions' of the data. Thus, analytical questions are raised in relation to each theory used. The researcher would, for instance, ask: What questions would Haugaard ask about this topic? This process would then be continued with other theoretical perspectives. The plugging in process is described as the process of producing "something new in a constant continuous process of making and unmaking the thing" (2012:1). The appeal of this method is that it combines the 'openness' of inductive analysis with theories that may deepen the analysis.

Using multiple theories to interpret data is well suited to this research for several reasons. Firstly, I concur with the view that a purely inductive analysis may fail to explain the research topic adequately and that theory is useful to deepen interpretation. Secondly, this research applies several theories. These theories all assume that data should be taken at more than 'face value'. In particular, Scott's theory of hidden and public transcripts urges us to consider different layers in the data. In this context, Mazzei and Jackson provide a relevant approach to data-analysis. Furthermore, theoretical triangulation is considered an important concept in establishing trustworthiness (rigour) in qualitative research (Flick, 2009).

However, this multi-theoretical method also raises questions. How will using several theories (as opposed to one) ensure that the data are not constrained to fit into (narrow) theoretical frameworks? In my view, the danger of understanding data within preconceived theoretical frameworks remains, irrespective of whether one theory or several theories are used. For this reason, the data analysis approach employed in this study combines Mazzei and Jackson's approach with an inductive approach. An initial inductive approach will attempt to ensure the inclusion of data that do not fit into any of the theoretical schemes. The second level of analysis consists of analysing data across multiple theoretical perspectives. The deductive phase build on the theories and conceptual understandings described in the previous chapter.

My approach to using theories differs from that of Jackson and Mazzei not only in that I combine it with an inductive process. Where Jackson and Mazzei present different interpretations of their data using different theorists, I use different theories and conceptual frameworks to contrast and explore meanings and raise questions about how to understand the data. Some frameworks are used to explore data from a certain angle. For instance, the *Powercube* is used to explore constraining expressions of power, while VeneKlasen and Miller's framework is used to explore enabling power. But I also contrast theories. For instance, I ask whether power is internalised, as proposed by many theorists, or met with resistance, as suggested by Scott. Thus, the aim of my data analysis is not to explore different interpretations based on different theories, but to reach some form of synthesised analysis through this. This is in contrast with Jackson and Mazzei, who do not attempt to synthesise their different theoretical readings.

The inductive data analysis starts with open descriptive coding and proceeds with data reduction and generation of analytical categories, a process described by, among others, Hesse-Biber and Leavy (2006) and Hennink, Hutter and Bailey (2011). The initial coding generated numerous descriptive codes, which were later developed into analytical codes and categories, before the different understandings of power described in Chapter 3 were used to analyse the data. Some theories are more prominent in certain chapters, while different theories take centre stage in other chapters. Finally, I read the analysis with a reflective approach. Table 2 below outlines the analytical process.

Analytical approach	**Method**	**Steps**
Inductive analysis	Open coding	Open listening. Assign open descriptive codes.
	Analytic coding Focused coding	Develop analytical categories based on descriptive coding (data reduction). Explore patterns, relationships, comparisons.
Deductive analysis: using multiple theories	Analysis according to Fung and Wright (2003c)	Generate questions for analysis: *What sources of countervailing power do health committees draw on?* *What potential sources are available?* *What is the strength of their countervailing power?* *How does presence/absence of countervailing power impact on health committees?*
	Analysis according to *Powercube* (2011 and Lukes's (1974) three faces of power.	Generate questions for analysis: *What forms of visible, hidden and invisible power are enacted in participation?* *Which forms are dominant?* *How do these forms of power impact on participation?*
	Analysis according to Haugaard's (2003) theory	Generate questions for analysis: *Which beliefs, assumptions, and tacit knowledge are internalised?* *How do participants perceive their 'place in the world'?* *Is tacit knowledge translated into discursive knowledge, and if so how?*
	Analysis according to VeneKlasen and Miller's (2007) framework	Generate questions for analysis: *Which forms of 'power to', 'power within' and 'power with' do health committees draw on?*

		What potential forms of power are available to health committees?
	Analyse according to Scott (1990) (and in contrast with Haugaard (2003))	Generate questions for analysis: *Are there public and hidden transcripts present and if so what are they?* *Do hidden transcript 'burst through' to the public arena?* *Is power internalised or does the enactment of power result in resistance through the creation of a hidden discourse?*
Synthesised analysis	Synthesise deductive and inductive analysis	
Reflective analysis	Reflective reading of the synthesised analysis.	Consider impact of researcher Participants' reflexive practice

Table 2: Data Analysis Overview

Data-analysis was aided by using Nvivo 10 for developing descriptive codes. Reflective memo writing also aided coding as well as formulation of questions for further data collection and framing of analytic questions.

4.6 Rigour

The concept of rigour is important to consider in qualitative research. Concepts such as reliability and validity used in quantitative research are not easily applied to qualitative research. Many theorists suggest other criteria to ensure the trustworthiness and credibility of qualitative research (Flick, 2009). This study draws on Lincoln and Guba (1985) and Flick (2009) to design a rigorous research project. The first mechanism to enhance rigour was that of prolonged engagement with the fieldwork taking place over almost two years. Prolonged engagement allows for a deeper understanding of the context and sufficient time to guard against misinformation and to collect sufficient data. Lastly, it builds trust with research participants, which enhances the quality of the data.

The second concept is that of persistent observation, which according to Lincoln and Guba enables a researcher "to identify those characteristics and elements in the situation that are most relevant to the problem or issue being pursued and focusing on them in detail" (1985: 304). The third concept is triangulation. According to Flick (2009), triangulation can take place at data or source level, at method level, at theory level and at investigator level.[17]

Triangulation in this study took place at data/source level, method level and theory level. At source level, I included both health committee members, facility managers, community members and other stakeholders. At method level, I used multiple methods. At theory level, I used a data analysis approach that allowed for different theories to be used in the data analysis. Thus, triangulation was built into the design of the case study. Triangulation was important not just as a way to testing findings, but also to provide a better understanding when different sources or methods led to different findings, such as contradictions between what health committee members said they did and, for instance, how they acted in health committee meetings. This was used both to explore these differences, but also to theorise about them. For instance, I used focus groups to explore why certain issues discussed amongst health committee members were not addressed with the facility manager. Choosing a multiple case study also allowed for constant comparison, which enhances the credibility of findings. When findings in the two communities differed, this prompted reflections on how this could be explained.

Credibility was further enhanced by member checking (Lincoln & Guba, 1985), which happened continuously throughout the study at data level. In other words, I would check continuously that I had understood what was said or what happened. In addition, I had focus groups towards the end of the fieldwork where I checked both data collected and preliminary analysis. Member checking was most useful at data level. Finally, credibility at the analytical level was enhanced through discussing preliminary and final analysis with colleagues and through presenting analysis at seminars and conferences.[18]

[17] Lincoln and Guba have a different view to Flick. They do not agree that triangulation on theory level enhances a study's trustworthiness (1985:307).

[18] Findings and preliminary analysis of this research were presented at the International Inquiry of Qualitative Research, Illinois, United States, May 2018, and the 5th Global Symposium on Health System Research, Liverpool, United Kingdom, October, 2018. In addition, they were presented at a SASH (South Africa Social Science and HIV research) research day in March 2017, and at the annual SASH forum in March 2018.

As noted by Lincoln and Guba, naturalistic inquiry cannot be assessed according to criteria such as external validity, as it takes place in open systems. Instead, Lincoln and Guba suggest that the concept of transferability should be used, and more importantly, that a qualitative study should provide sufficient 'thick description' for readers to be able to assess transferability. Hence, the study does not aim to discuss whether these findings are transferable or generalizable, but it provides rich data to understand in which contexts the findings may be transferable. Furthermore, while the findings may not be generalizable on population level, they contribute to theoretical propositions about power and participation, which may be more easily transferable.

Dependability and confirmability are two concepts used in qualitative research, whereas quantitative research relies on validity and reliability. An important mechanism to ensure that a study's dependability and confirmability can be assessed is to keep an audit trail. This study used Nvivo 10 to assist in data analysis. Using this software helped manage the data and to create an audit trail. All raw data including field notes, recordings, steps in the analytic process such as memos, codes, categories and preliminary analysis were kept in Nvivo.

4.6.1 Reflexivity

Reflective practice was important in this research because of my positionality as an insider-outsider researcher and because of my identity as a White, middle-aged woman who grew up and spent the early part of my adulthood in Denmark. I will address my identity first and then my position as an insider-outsider researcher.

Given South Africa's colonial and apartheid history and current context of racial and class divisions, my racial and class background is import. In terms of power, it is evident that I could easily be seen as representing powerful sections of society. It is a dilemma for researchers who represent privilege and power whether they should conduct research in marginalised settings. I believe that if done with sensitivity and reflexivity such research can contribute to understanding power dynamics and find ways of addressing these.

On the other hand, my identity as 'non-South African' (White) may have been an advantage. I believe my accent – and probably also my 'habitus' – conveys that I did not grow up in

South Africa. It has been my experience in my previous career as a journalist and as an anthropologist working in public health that this identity can be an advantage as I carry less particular South African White 'baggage'.

Furthermore, I grew up in a society where class divisions are much less pronounced and in a society and a family with strong egalitarian values. I bring them into my work and probably see the world through that lens. This may not only have influenced my interest in understanding power in a context of huge power differentials, but also in my approach to understanding power and in the way I interpret both the South African laws and the lived experience. As an outsider, my perspective may shed a particular light on this context.

It is evident that my personal experiences and life circumstances are vastly different to those of the study participants. While I believe my training and experience both as a journalist and an anthropologist have prepared me to understand other people's life circumstances, it is obviously an ongoing challenge to fully grasp other social and psychological worlds. In particular, it may have been a challenge for me to fully understand how peoples' experiences have resulted in forms of internalised power.

I attempted to mitigate my positionality through a sensitive and reflective approach and through prolonged engagement, which built rapport and trust and enabled me to better understand the context I worked in. Prolonged engagement is also more likely to ensure that participants felt comfortable sharing their experience. Through the course of prolonged fieldwork, relationships are built and the extended time period allowed us to relate as people rather than as representatives for certain racial and class categories.

My work experience and engagement with health committees also call for reflexivity. Since 2010 I have been part of the Learning Network on Health and Human Rights and through this I have extensive experience working with health committees and conducting research with them. I conducted an audit of health committees in Cape Town between 2010 and 2012, and published the findings in a report (Haricharan, 2012). The findings were presented in meetings and at seminars and conferences.[19] The findings from this study was used to design

[19] This research was presented at the following conferences: Public Health Association of South Africa, Johannesburg, 2012; British Institute of Eastern Africa, Nairobi, 2012; International Congress of

a project with health committees in Cape Town aimed at improving their functionality and impact. The project was conducted between 2012-2015. As part of this project I conducted a rapid appraisal of South African provincial health policies (Haricharan 2015a), designed a capacity-building project and contributed to the writing of a training manual for health committees (Haricharan et al., 2014). I also conducted an evaluation of the project (Haricharan, 2015b) and was part of crafting the Learning Network's submission on the Health Facility Boards and Committees Bill (described in Chapter 5). My prior involvement with health committees meant that I came to the research with a set of experiences, knowledge, beliefs and biases.

The formulation of the research questions has been influenced by my work with health committees. Firstly, it is based on a belief in the positive value of participation as a way of deepening democracy and contributing to the right to health. Given my positionality, it was important to remain open to the possibility that the research would produce findings that were in contrast with my assumptions, such as the possibility that invited participation was ineffective in expressing community views in the health system. In the data-collection phase I paid particular attention to posing open-ended questions beginning with 'tell me about'. This was done to attempt to capture people's uncensored opinions and not project my own views. I also attempted to paraphrase their answers and ask if I had understood them correctly.

The choice of power as a theoretical/conceptual lens used to understand participation is also influenced by my previous experience. The focus on power and hidden transcripts is partly a result of a belief that previous work focused too much on observable barriers to participation and a conviction that these barriers were only partial answers to understanding health committees' challenges. However, there was obviously a risk that this lens would result in not being open to other important issues emerging. Reflexivity in the research process therefore also consisted of questioning the theoretical approach and reflect on whether other factors could better explain the research question. A flexible study design and a multipronged data-analysis approach allowed for reflexivity to guide the research.

Qualitative Inquiry, Illinois, United States, 2013; Municipal Service Project Conference, Cape Town, 2014; 3rd Global Symposium on Health System Research, Cape Town, 2014.

During the data collection phase I wrote field notes which contained reflexive notes on the research process, on my role as researcher, on my own biases, beliefs and assumptions. These included reflections on how my research impacted on the participants and their practices. The data-analysis phase contained several analytical phases. In a 'reader-response reading', I reflected on how I responded to and related to the data and reflected on this (Mouthner & Doucet, 2003). Revisiting topics, continued member checking, and presentation of preliminary findings also presented opportunities for reflexivity.

My dual role as researcher and collaborator in an intervention project meant that I sometimes had to negotiate expectations with the urban health committee, where some members had been part of the Learning Network training. They requested my assistance in other regards.

In addition, there were also situations where I had to guard against influencing health committees' actions. This became particularly important during the last six months of the research when implementation of the *Western Cape Health Facility Boards and Committees Act 2016* (2016) began. I was conscious of not wanting to influence this process, but rather observe it as I was interested in seeing how it was handled by the Western Cape Department of Health, the health facilities and, particularly, the health committees. This led to a difficult choice whether to inform the rural committee of the deadline for nominations as I suspected they may not have been informed. I chose not to communicate this to them as this could be interpreted as me interfering in the process. In the end, it turned out that they had not been informed and hence missed the deadline.

Another challenge I had to negotiate was participants asking we to intervene or take part in actions aimed at changing their participation. Focus group discussions often spurred participants to want to take action. I welcomed these discussions and allowed them to continue, though I made it clear that I could not be part of attempting to make changes due to the design of my study and my role. I had deliberately chosen a qualitative case study over an action research study, which according to Stringer is "a systematic approach to investigation that enables people to find effective solutions to problems they confront in their everyday lives" (Stringer, 2014:1). In comparison to many other forms of research, action research involves participants as active partners in the research and the aim of the research is action. It is a form of research that was envisioned for the Learning Network on Health and Human Rights because of its transformative qualities.

The reason for not conducting an action research study, which may seem a suitable choice, was that I had specific questions and theoretical positions that I wanted to explore. I was convinced that a deeper understanding of how power operates in participation would be useful not just from a theoretical perspective, but also from a practical point of view. However, I believed that this would be better studied in-depth without implementing change simultaneously. This does not mean that I do not believe that it is important that research should have a purpose beyond knowledge generation. It is envisioned that a number of interventions could be based on the knowledge created, both at policy and practice level. I believe the kind of knowledge created may not have been generated through an action research project. Nevertheless, participants took at times a more active role in the research, for instance by suggesting topics they would like to discuss in focus groups, something which could easily be accommodated given the flexibility of the study design. They would also use these opportunities to discuss which actions to take. In these instances, I stepped back and observed.

During the research process it became clear that the research also provided a space for critical reflexivity for research participants. This space was used to reflect on their practices, explore possibilities and discuss strategies. Understanding constraining aspects of power enabled them to address these factors and draw on more enabling forms of power. Thus, as will be described later, the focus group discussions in the urban committee sometimes resulted in suggestions to take action. Participants argued that the research – the discussions – became an important site for reflections, as described further in Chapter 7. It is probably inevitable that long-term ongoing research will have an impact on research participants. While I attempted to minimise the impact by making my role as a researcher clear, it is important to acknowledge that asking questions, probing, asking people to reflect on their role is likely to impact on participants' perspectives and possibly their actions. The research process provided a space for critical reflexivity for research participants and led them to initiate strategies on improving participation. This can be considered a limitation, but it can also be considered an important finding (as will be explored in Chapter 7).

4.7 Ethics

The research adheres to the ethical principles outlined in the *Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects* (World Medical Association, 2001) and thus attempted to minimise potential risks and maximise benefits for participants. The research was approved by University of Cape Town's Health Science Faculty's Human Research Ethics Committee (No. 460/2016) (Appendix C) and permission to conduct the research at the two sites was granted by the Western Cape Department of Health. The study also complies with the *Ethics in Health Research: Principles, Structures and Processes* (Department of Health, 2015).

4.7.1 Recruitment and informed consent

Before research commenced, an assessment of risks and benefits was done, and the research was deemed to have more benefits than risks as it was envisioned that research participants would learn from discussing and reflecting on their experiences. The primary risk identified was potential conflict within health committees, or between committees and facility managers. In case this occurred, I offered to identify and organise sources that could mediate.

A key aspect in the Declaration of Helsinki is that of voluntary participation and informed consent. The consent process with health committees ensured that potential participants were duly informed in information meetings. Participants were informed that their participation was voluntary and that there were no repercussions if they chose not to participate. They were also informed that they could withdraw from the study at any point. Translated information sheets were made available and questions were answered at the information meetings. After the information meetings, health committees were given time to discuss their participation before they informed me of their decision. An example of an information sheet is attached as Appendix D, while an example of a consent form is attached as Appendix E. Written information sheets and consent forms were translated into Afrikaans and isiXhosa. Participants were asked to read the information sheet and asked if they had any questions before giving their written informed consent.

4.7.2 Privacy and confidentiality

Participants' privacy and anonymity were guaranteed to the extent that this was possible. Because of this, participants are given pseudonyms and personal identifiers are only used in this thesis to the extent that this does not infringe on their anonymity. Participants were made aware that complete anonymity and confidentiality cannot be guaranteed in focus groups or observations. Translators were made aware of ethical principles. The chairperson of the Upper Structure stated that he would like to be referred to by his real name, but in order to protect the anonymity of other participants, he is also given a pseudonym.

4.8 Introducing the health committee members

This section provides a table with information on the main participants in this study, the health committee members. All data were relevant as of the start of the research period.

Name	**Age**	**Gender**	**Educational level**	**Occupation**
Urban Committee				
Nkosi	53	M	Matric	Unemployed
Neliswa	40	F	Unknown	Unemployed
Nonzwakazi	30	F	Grade 11	Unemployed
Xholisa	42	F	Grade 11	Unemployed
Thando	29	M	Grade 11	Baker
Sipho	25	M	Matric	General worker at supermarket
Sibongile	22	F	Matric + diploma	Student
Luyo	34		Grade 11	Traditional healer
Beatrice	42	F	Matric	Unemployed
Elizabeth	24	F	Grade 8	Unemployed
Rural Committee				
Laurie	61	M	Teacher's diploma	Retired principal
Patricia	58	F	Grade 8	Farmworker
Marike	50	F	Grade 10	Unemployed
Kenneth	48	M	Matric	Co-ordinator
Laura	57	F	Grade 9	Cleaner
Elise	42	F	Grade 8	Farmworker

Table 3: Demographic data for health committee members

Other participants:

Mr C. …….....The facility manager at the urban clinic
Sister B……The facility manager at the rural clinic
The MEC
Sandile……..SACP regional chair
Lara Ndlovu…… TAC representative
Mary Coetzee….. sub district manager
Numerous community members and representatives from organisations.

4.9 Conclusion

The methodology chapter outlined why a multiple qualitative case study with an urban and a rural committee was suitable to address the research questions. It outlined how different qualitative methods were employed to explore the complex research questions and how a data analysis approach ensured that the questions were explored through different theoretical lenses of power. The chapter described the study sites and the health committees, and outlined how prolonged engagement, member checking, triangulation and reflective practice have been incorporated into the study to ensure rigour in the research process. Bearing in mind Lincoln and Guba's assertion that in an open system "no amount of member checking, triangulation, persistent observation, auditing, or whatever can ever compel; it can at best *persuade*" (1985:329), I proceed with the content chapters.

5 An invitation to participation? The invited space for health committee participation in the Western Cape

5.1 Introduction: the invitation to participation

The hall at Lentegeur Hospital in one Cape Town's Coloured townships is filled and there is excitement in the air. This meeting, held on a warm March day in 2016, is the first time the Western Cape Health Department has invited community members to a meeting where they present the Department's budget. Many community members and health committee members have accepted the invitation. The invitation is significant: it could be viewed as a clear indication that the Department of Health is serious about community engagement. From all corners of Cape Town, community members and organisations have come to hear the provincial health minister and health officials speak. Amongst them are also members from the urban health committee, which was part of this study.

The provincial health minister, the MEC, addresses the gathering before the budget is presented. She uses the occasion to talk about another invitation: an invitation to participation. Like the invitation to the budget meeting, the invitation to health committees is aimed at strengthening links between the health sector and communities. Eight months earlier the provincial legislature passed the Western Cape Health Facility Boards and Committees Act 2016 (2016), which gives legal recognition to both hospital boards and health committees linked to primary health care facilities. With this legislation, health committees in the province finally have a legal mandate. The legislation can therefore be seen as an invitation to participation. Having a legal mandate formalises health committees as invited spaces, understood as spaces where citizens engage with health officials.

From the podium at the Lentegeur Hospital, the provincial health minister speaks about the significance of this Act. She outlines how health committee members will now have power, a power they get through being appointed by her, the provincial minister. If they have issues, they can call her because they are to be appointed by her, she further explains.

Fung and Wright (2003c) argue that participation without collaborative countervailing power is likely to fail. In other words, those in unequal positions of power in a participatory forum must have alternative source of power – a countervailing power – to realise effective participation. Furthermore, they argue that a likely source of countervailing power is a policy.

This raises the question: does the Act provide health committees with a source of countervailing power that is likely to result in successful participation? This chapter attempts to answer this question by analysing the Act and the invited space it creates. It does this by drawing on the conceptual approaches to participation outlined in Chapter 2 and by considering how power is imbued in the legislated participatory space and how it operates in the creation of this space. Bearing in mind Cornwall's (2002) assertion that it is important to consider how much influence people have in the process of creating legislation, I argue that both the content of the Act and the consultation process leading up to the adoption of the Act contributed to shaping this invited space. Understanding this space therefore entails understanding both the consultation process, the content of the Act, and how health committees experienced the consultation process and understood the Act.

Though the invited space is formally being created with the Act, health committees had existed for years and there has been a legal commitment to health committee participation in the *National Health Act, No 61 of 2003* (2004). Thus health committees had existed as invited spaces, albeit with no clarity on their formation or roles, as the NHA defers this to provincial legislation. The participatory space is therefore not created on a clean slate, but in a context where actors have previously engaged in participation.

The following section provides an analysis of key aspects of the Act and the power embedded in it. This is followed by sections focusing on health committee members' understanding and perception of the Act, and on the consultation process preceding its promulgation.

5.2 Analysis of the Western Cape Health Facility Boards and Committees Act

5.2.1 Appointed participation – who is invited and who does the inviting?

A legalised participatory space, such as the space created with the Act, is a space where citizens are invited to participate. Important questions to ask in analysing the Act are therefore: who is invited and who does the inviting? The Act embraces a model of ministerial appointments where the MEC appoints health committees (*Western Cape Health Facility Boards and Committees Act*, *2016*:ss6(1)). Appointments will be based on nominations from a body that, in the opinion of the MEC, is sufficiently representative of the interests of the

community or communities concerned (2016: 6(3)(a)). The Act, then, embraces a top-down model, where the MEC has final control over who participates.

It is also worthwhile considering who is invited and qualifies to enter the invited space. Depending on how the word 'body' is understood, this may exclude groups, sections, and individuals who are not part of community structures, are 'unorganised' or part of unrecognised social movements. Furthermore, the Act (2016:ss6(7)) prescribes that the MEC should pay attention to issues of age, gender, race and disability, categories that are often considered necessary to ensure inclusivity. However, the issue of who is invited also raises the issue of who is not invited and what the rationale is behind giving preference to certain categories. Illustrative of this, one might ask why groups such as migrants and the LGBT community – groups that are known to face barriers when accessing health care – are not represented (Human Rights Watch, 2009; Muller, 2017).

Participatory theory, human rights and PHC approaches to participation agree that one of the purposes of participation is to give a voice to marginalised citizens (Potts, 2008a; Hilmer, 2010). It is evident that the Act has made limited provision for inclusivity.

5.2.2 What are the terms of the invitation? Roles, level of participation and support

Invited spaces are, as noted, spaces where the terms for the invitation are predetermined by those creating the space. In the Act roles are split into duties, which are defined as roles that health committees *must* perform, and powers, which are defined as roles that a committee *may* perform. All roles are related to a primary health care facility. Table 4 below outlines duties and powers respectively:

Duties of committees: roles health committees must undertake
Request feedback on measures taken by the management of the primary health care facility to improve the quality of service at the facility.
Assist the community to effectively communicate its needs, concerns and complaints to the management of the primary health care facility so that the needs, concerns and complaints can be appropriately addressed.
Foster community support for the primary health care facility.
At reasonable times and in cooperation with the management of the primary health care facility conduct scheduled visits to the facility, without impeding its functioning, and provide constructive written feedback on such visits to the management.
Encourage volunteers to offer their services in performing general duties in respect of the primary health care facility in accordance with the applicable policy on volunteers.
Provide constructive feedback to the management of the primary health care facility in order to enhance service delivery.

Powers of committees: roles health committees may undertake
Conduct surveys, meetings and consultative workshops in the community.
Disseminate information to the community or communities concerned on the mission, vision, values, services, performance, standards, policies, strategies, needs and financial status of the primary health care facilities.
Advise and make recommendations to the Provincial Minister, the management of the primary health care facility, the Head of Department or the municipality concerned, as the case may be, on any matter relating to the performance of the Committee's functions.
Obtain information it requires from the management of the primary health care facility if the information does not violate the rights of a patient or staff member to privacy and confidentiality.

Request from the management of the primary health care facility copies of routine progress reports that have been generated.
Conduct fundraising activities for the benefit of the primary health care facility and the functioning of the committee.

Table 4: Duties and powers of health committees in the *Western Cape Health Facility Boards and Committees Act, 2016* (2016:s12-13).

The approaches to participation presented in Chapter 2 all view participation as *influence in decision-making*. Some argue that full participation requires control over decision-making (Pateman, 1970; Arnstein, 1969), while others consider joint decision-making participatory (Potts, 2008a). Notwithstanding these varying opinions on how much decision-making power is required, some influence in decision-making is central in defining participation. Moreover, I have argued that participation in health, according to the approaches presented, should entail involvement and decision-making in priority setting, planning, implementation, accountability and policy – in short, health governance.

In relation to health committees' duties (roles), it is evident that health committees do not have roles in health governance – in priority setting, planning, implementation and accountability. It is equally clear that their influence in decision-making is limited. Consider the language used to outline their duties. They can 'assist' communities to communicate their needs but have no power to ensure that the facility addresses those needs and no input into how they should be addressed. They can 'provide constructive feedback', but there is no obligation on the facility to respond to the feedback or address issues raised.

With regards to health committees' 'powers', similar contradictions are evident. Importantly, it is unclear when they 'may' execute these powers and who makes decisions in this regard, making them weak and contingent in nature. Health committees, hence, have no real influence or power to enforce any of these roles. Again, the language used is important to consider. They can 'request feedback' on progress reports and 'obtain information', but they have no right to expect they get the information, since health services are not obliged to provide this. For both duties and powers, it is my contention that the language used constitutes a layer of hidden power which minimises health committees' role as there is no

obligation on the health services to respond to health committees' requests, feedback or concerns. Hidden powers are here understood as powers that prevent issues from reaching the decision-making forum (Powercube, 2011).

An important clause in relation to health committees' roles appears in section 14 of the Act, which gives the MEC power to revoke or extend roles. It is stated that changes to the prescribed roles should be in the public's interest, and this is supposed to happen in consultation with the health committee in question and be based on an assessment of the health committee's capacity to perform a certain duty. Nevertheless, this gives the MEC absolute power in relation to determining health committees' roles and defining the terms of participation. In other words: health committees have limited power and influence. The ability to change the extent of their power and influence is entirely within the power of the MEC. Overall, there is no obligation on the health services in terms of roles. Therefore, I argue that participation becomes a privilege rather than a right, a privilege that can be granted by the MEC, but not a right that citizens have.

A comparison between health facility boards and health committees is illustrative of how narrowly health committees' duties are defined. For instance, health facility boards are assigned a role in participating in strategic planning in an advisory role. They must also monitor performance, effectiveness and efficiency of the facility and take measures to improve these (Western Cape Health Facility Boards and Committees Act 2016, 2016:ss10 - 11). Health committees do not have such roles. Furthermore, hospital boards can according to the Act "take measures to ensure that the needs, concerns and complaints are addressed by the management" (2016:ss10(1)(c)). Compare this to health committees' role in this regard, which is limited to assist the communities to express their views.

Overall, it is evident that the roles granted to health facility boards are far more consistent with a conceptualisation of these structures as governance structures. The *Western Cape Health Facility Boards and Committees Act 2016* was created to replace a previous Act on health facility boards, and many of health facility boards' duties and powers are similar to those in this Act (*Western Cape Health Facility Boards Act*, *2001* (2001). In contrast, none of the roles envisioned in the *Draft Policy Framework for Community Participation/Governance Structures in Health* (Western Cape Department of Health, 2008) on health committees were carried over to the current Act. Hence, there has been a clear shift

in how health committees have been conceptualised over the last decade. In the Western Cape Draft Policy (2008) health committees were viewed as governance structures with roles in planning and monitoring health service delivery. These roles are absent in the current Act. These narrowly defined boundaries should be considered a form of hidden power as these provisions prevent issues from being raised.

Similarly, a comparison between the Western Cape Act (2016) and the national *Draft Policy on Health Governance Structures* (Department of Health, 2013) shows that the Western Cape Act has weaker governance and accountability roles. The *Draft Policy on Health Governance Structures* has roles such as 1) assisting in policy and strategy; 2) advising; 3) assisting in monitoring performance; 4) right to receive necessary information; 5) receive reports on progress; and 6) conduct regular structured visits to monitor progress. Furthermore, roles include 7) review of financial reports; and 8) assist in the appointment and staff, and monitoring investigation and resolution of complaints. It is evident that these roles are more in line with a PHC and a human rights approach. It is also important to note that the national Draft Policy paper has the same roles for district health councils, health facility boards, and health committees, whereas the Western Cape Act on health facility boards and committees outline different roles for these structures. Hence, there is a lack of agreement between the national Department of Health and the Western Cape Department of Health on how to conceptualise health committees.

An important aspect in both a human rights and a PHC approach to participation is that participation should occur both at local, national and global level. As the description of roles has demonstrated, health committees are considered localized participatory structures focusing on local health facilities. Notwithstanding the debate around whether participation at local, national or global level is more effective, an important feature in the Act is the limited articulation of participatory structures horizontally and vertically. While the Act highlights facility managers' roles in fostering collaborative working relationships by stipulating that the minister *may* take measures to ensure collaborative working relationship between health facility boards, committees and district health councils *(Western Cape Health Facility Boards and Committees Act, 2016*, 2016:ss16(1)) there is no obligation to ensure that this occurs. There are no structural linkages for upstream influence in the health system to provincial and national level. Tiered structure for community participation – from local to sub-district and district level – are lacking. Such structures have existed in Cape Town since 1992 when the

CMHF began to organise health committees. Such structures are also envisioned in the *Draft Policy Framework for Community Participation/Governance Structures in Health* (Western Cape Department of Health, 2008). However, the Act does away with coordinating structures at sub-district and district level.

Importantly, there are some provisions for support in the Western Cape Act. The facility manager *must* "take measures to assist the Board or Committee concerned to perform its duties and exercise its power" (2016:ss16(3)(a)). Some concrete provisions for support are also mentioned. Firstly, the facility is obliged to provide a venue, and "in so far as is possible, secretarial, administrative and financial accounting support required by the Committee" (2016:ss18(4)). Secondly, the Department must provide induction and training for newly appointed members and additional training if considered necessary and appropriate (2016:ss18(8)). The final provision relates to providing reimbursement for transport expenses (2016:ss25(3)(b)). Hence, there are provisions for support, but some of these are expressed as a possibility, not an obligation.

Additionally, it is important to note what is absent in the Act. Consider, for instance, that there is provision made only for transport costs, but no other expenses such as for phones and stationery, which are necessary for committees to function, in particular because health committee members often belong to the poorest sections of the population. It is clear that there are barriers to participation, some visible, others more indirect.

Creating a supportive environment is important in realising one of the aims of participation: to make the voices of those not normally heard count. The *Powercube*'s argument that a policy framework for participation is disempowering if it does not facilitate participation (Powercube, 2011) should be noted. Seen in this light, the Act's framing of support, mostly as a prerogative for the Department to grant, can be considered a form of hidden power that is likely to impact negatively on participation. By the same token, omitting to create conditions for participation can be viewed as a form of hidden power that is likely to contribute to a limited form of participation.

Overall, the Act provides a mandate for health committees. In so doing, it can be said to provide a form of countervailing power. However, the design of the legislation limits health committees' countervailing power by making it contingent and conditional. The system of

appointment is one way in which countervailing power is eroded, because it enables the MEC to control who participates. The Act's limited roles and the MEC's final decision on health committee roles further restricts health committees' influence and power. The Act's limited and conditional support may also impact on health committees' capacity and ability to participate. Thus, all in all, the terms of the invitation make at best for a limited form of participation that is inconsistent with the approaches for participation outlined in Chapter 2. The wording of the Act means that health committees can seek influence only from a position of seeking privileges granted by the health services, rather than as claim-making agents. Conceptualising participation as a privilege rather than a right is a form of hidden power, bearing out the *Powercube'*s indication (2011:71) that when someone is granted something as a privilege rather than a right, it is about a form of power.

Appointed participation should then be considered a particular form of invited participation, a form of participation where substantial power resides with the health services and its political head. Hence, rather than talking about invited spaces, it makes sense to consider the specific conditions of the invited space in question.

As described in the introduction to this chapter, the Act was presented at a public meeting as an Act that would give power to health committees. But because it simultaneously minimises health committees' powers, the legislation creates a space that enables health officials to engage in participation, while at the same time putting in place a form of participation that can be controlled by actors in the health services. This resonates with Fung and Wright's argument that bureaucrats can engage in participation while at the same time protect their prerogative to act autonomously (Fung & Wright, 2003c:264). The content of the Act analysed in this section sets the condition for participation, but I have argued that the invited space is also shaped by how local health committee members understood, perceived and responded to the Act, which is examined in the following section.

5.3 Health committee members' perception of the Act

5.3.1 The Act as an opportunity

The adoption of the Act was viewed as a significant step by the two health committees. They expected that having legal recognition would give them a mandate and authority. The rural

health committee viewed the adoption of the legislation positively, believing that it 'gave them a platform'. In particular, it was seen as a way for the health committee to connect with provincial and national health authorities. "Dialogue and communication with the Health Department can help … We can use this committee, and if we know our rights we can stand on the platform and hold the government accountable," reflected the chairperson. This was contrasted with the current health committee's experience of being seen by the facility as a "body that sort of has no authority", as Laurie, the chairperson of the rural health committee, put it.

The Act, in other words, was viewed as providing health committees with collaborative countervailing power. This was particularly important for the rural committee, because the committee generally felt that the relationship with the facility manager hindered them in fulfilling their role. She was viewed as someone who controlled their participation and was able to do so because they 'had no authority' (no power). With the Act, they expected to have more power. "I think that she [the facility manager] has been thinking 'You guys don't really know your roles and responsibilities, let us keep it like that'. Now it is becoming clear that we can have an input," argued the chairperson.

The urban committee also expressed appreciation that legislation had been passed because it meant that health committees became recognised. It gave them a mandate and recognition as an official structure. However, they already worked with a facility manager who was more collaborative and supportive. Official recognition was therefore not as important for them as it was for the rural committee.

5.3.2 The system of appointment

Despite health committees welcoming the Act, there were also many concerns raised. Both committees opposed the system of appointment of health committees. It was argued that appointed health committee members could not be viewed as representing communities and hence such health committees could not be seen as legitimate community participation structures. The health committees preferred a model where community organisations choose health committee members, a model that is said to have been implemented in many

committees in the past, though research suggests a lot of variation in how health committees were formed in the Western Cape Province (Haricharan, 2012).

The opposition to appointed participation also gained traction because of lack of clarity on how the nomination and appointment process would unfold and what the criteria for appointments would be. There was a strong belief that the MEC should not appoint, because she is perceived to have limited knowledge about communities. **"**It is not good for the minister to appoint because she does not know the dynamics of the community and what it takes to be a community representative," argued Thando from the urban committee. The following comment from Nkosi, the secretary of the urban committee, is also illustrative: "We asked the MEC: how are you going to appoint? How will you know who represents the community?". An outspoken rural health committee member believed the MEC would ask the facility manager to appoint the committee. Elise was convinced that the community would reject a health committee appointed by the facility manager because she was unlikely to appoint those who challenge her. "She would target those who are outspoken and overrule them," argued Elise.

There was a fear that the minister would appoint people who did not have the communities' interests at heart. On a similar note, the urban committee members were concerned that the health committee would be composed mainly of members of the local TAC (the urban health committee's somewhat adversarial relationship with TAC will be explored in the next chapter). Others expressed concerns that appointments would be based on favours, be made in a non-transparent manner, would exclude 'community people' and be based on politics. This despite the fact that the Act specifically states that political parties should not be represented on health committees. Members asserted that the system of appointment limits community participation. "She [the MEC] acts as someone who encourages community participation. While at the same time she is limiting community participation. Her agenda is to work with people she feels comfortable with," argued Yeliswa from the urban committee. The system of appointment, then, is viewed as a way of neutralizing and controlling participation. The rural facility manager was the only one who felt that appointing health committee members would be appropriate, because it would ensure that 'the right people would be on the committee'.

5.3.3 Roles and powers

The roles outlined in the Act also preoccupied health committees. There was general unhappiness with the limited roles, in particular when compared to the roles of health facility boards. Some health committee members highlighted specific duties. For instance, the chairperson of the rural committee expressed concerns about the duty to provide constructive feedback to management. He felt that the wording indicated that health committees were expected to be positive and argued this was unacceptable in a context where health committees may have negative issues to raise. Questioning the meaning of the word 'constructive', he gave his own interpretation: "I understand that as being positive, that is somewhat of a problem. There is more negative stuff. What is constructive?" he asked. Many people also commented on the issue of fundraising, arguing that it was unfair to expect health committees to fundraise for the facility and health committees, while no budget allocation was set aside for the functioning of committees. The issue of encouraging volunteers was another contentious issue.

The rural committee's discussions about the Act were to a large extent framed as a question around whether they would be able to carry out the roles prescribed in the Act. Their experience indicated that this would be difficult. In particular, lack of access to information and funds were seen as barriers. How could they disseminate information to the community about the "mission, vision, values, services, performance, standards, policies, strategies, needs and financial status of the primary health care facility" (Western Cape Health Facility Boards and Committee Act 2016, 2016:ss13(1)(b)), when they did not have access to such information themselves. "If we were to provide the community with information, which the Act talks about. We don't have that information. Where is the information?" asked Laurie. As described previously, health committees can only request information, but do not have a right to information, which effectively means that the facility can control what information is made available. (In chapter 7, I will explore the issue of access to information.)

Another duty, which rural health committee felt they were not equipped to carry out was that of conducting surveys, meetings and consultative workshops in the community (2016:13(1)(a)). As the Act does not provide for any financial assistance, the health committee were adamant that this task was simply impossible. Finally, the rural health committee argued that they would struggle to carry out the majority of their duties because of

a non-collaborative relationship with the facility manager. Their experience during the health committee's two years of existence had been one of limited collaboration and difficulties in getting the facility manager to attend meetings. Consequently, there was very little trust that things would happen according to the Act, once implemented.

The rural committee also raised the issue of limited engagement with higher levels of the health system, as their experience was that higher-level engagement was necessary. Their vision for health committee participation included having an accountability role and engagement with the wider health system.

The urban committee focused on what was lacking in the role description. Here, the fact that health committees do not have influence on the budget was emphasised as a problem. One of the urban committee's current primary tasks, that of complaint management, was omitted in the Act. While the committee played an active and expanding role in dealing with complaints, the Act limits their involvement to "*assist* the community to effectively communicate its needs, concerns and complaints" (my italics) (2016:s12(b)). This led some urban health committee members to question whether they should continue to do what they were already doing, indicating that they might consider operating outside the confines of the Act.

There was also great confusion and contestation about the fact that health committee roles were divided into duties and powers. Questions were raised about when health committees could carry out the roles described as powers. "The 'may' part … We need to check the powers of committees. They cannot say you 'may' do this; you do have the rights. They don't give us the authority," said Beatrice.

A member of the urban committee interpreted the section on revoking or extending roles as a signal that the Department was not serious about community participation. The comment below indicates a perceived political ambivalence about community participation.

> I want to touch on the 'may' part [in the Act]. You as government you are not even sure about yourself. 'I may at times allow certain things, at other times not.' The Department has gone out to seek community participation, but also pushes the community away. They are not comfortable with community participation. (Beatrice)

The health committees were also concerned with the MEC's power to revoke duties. The chairperson in the rural committee argued that if the Department felt that a health committee did not have capacity to carry out a certain duty, they should capacitate it, rather than revoke its duty:

> How can you take roles and duties away? A core responsibility of the Health Department is to see that committees are being capacitated – but then they talk about not having the capacity. Don't switch it around. Instead look at the question and capacitate the committee. [It is] irresponsible to take powers away. They should capacitate instead. (Laurie)

Overall, health committees were critical of the Act's description of roles and viewed it as curtailing their power. At times the criticism of the Department and the Act was scathing as committees felt somewhat disempowered by the Act. It became clear that as much as health committees were committed to community participation, there were also layers of mistrust and a fear that the health services were not serious about involving and empowering communities: "You can pick up that they want us to sing the same song as the Bill," commented Yeliswa. The following comment from Nonzwakazi also illustrates health committee members' critical view of the Department's approach to participation:

> How I view the Act is that government wants health committees and needs health committees, but on the other hand wants to limit their powers. They use health committees, wants them to move on their terms. If the Department says dance, health committees must dance. (Nonzwakazi)

In both committees, concerns were raised about the level of support that health committees would be given to carry out their mandate. In particular, financial resources were considered insufficient. Questions around whether the support that facilities were requested to provide would be forthcoming were also raised. Health committee members stressed that participation suffers when they have no resources for phones, for instance, and no running costs for the committee and community work.

Up to this point I have analysed the kind of space that is created through the Act and the health committees' experience and perception of the Act. I argued that in the legislated

invited space, substantial power remains with those creating the space and the legislation, in this case the Department, unless processes ensure that other actors such as health committees have influence on the design of the space. In the following section, I explore how much influence health committees had on the design of the Act and how they experienced the consultation process leading up to the drafting and adoption of the Act. All of this contributes further to understanding the invited space being created for health committee participation in the Western Cape.

5.4 The consultative process: an illusion of consultation?

When health committee legislation was promulgated in 2016, it ended a long impasse. Health committees and the Cape Metro Health Forum (CMHF) had called for legislation for years when the Act was first promulgated, 12 years after the NHA (2004) provided framework legislation for health committee participation.

Before the Act was drafted, an engagement process took place between the provincial Department of Health, community structures and health committees, followed by a formal public participation process. Health committees and concerned community members also marched to the provincial parliament after the release of the first version of the Bill to demand input into the Bill and raised their concerns in particular about the model of appointing health committees. Table 5 below captures important dates for the engagement process:

Date	**Event**
2012	The Western Cape Department of Health makes a decision to amend the 2001 *Health Facility Boards Act* to also make provision for health committees.
May 2014	The Cape Metro District Health Council holds its first consultation meeting.
February 2015	The Cape Metro District Health Council

	holds its second consultation meeting.
May 2015	The *Western Cape Health Facility Boards and Committees Bill* is published.
July 2015	The Cape Metro District Health Council holds its third consultation meeting.
July 2015	Written submissions on the Bill.
October-November 2015	PHM training on the Bill.
December 2015	Health committees and community members march to the Western Cape Department of Health to demand influence on the legislative process.
March 2016	The second version of the *Western Cape Health Facility Boards and Committees Bill* is published.
April 2016	Written submissions on the Bill.
May 2016	Oral submissions on the Bill.
July 2016	The Act is adopted.

Table 5: Timeline of the engagement process

The consultation meetings constituted opportunities to influence the content of the then Bill. The engagement process was not organised by the provincial Department of Health but was managed under the auspices of the District Health Council for the Cape Metro (the DHC),[20] which considered promoting community participation part of its mandate. It is uncertain whether the Department would have engaged with communities had meetings not been

[20] A district health council is a legislated council linked to a health district. Members are appointed by the provincial health minister. The *Western Cape District Health Council Act* (2013) prescribes that the councils should be composed of a member of the municipal council, a person representing the MEC, a member of the council of each local municipality within the health district and up to five additional members. In the Cape Metro two community members are appointed as additional members, but there is no legislative requirement to have community representatives on the Council (*Western Cape District Health Councils Act, 2013)*.

organised by the DHC. The consultation process consisted of three meetings where the content of the legislation was discussed, two before the first Bill was published in 2015 (Western Cape Department of Health 2015), and one after the Bill was published. The public participation process consisted of public hearings with oral and written submissions and took place between July 2015 and July 2016.

The first two consultative meetings discussed the impending legislation in addition to setting criteria for what constituted a functional health committee. Interim recognition of existing health committees was discussed and agreed to. The meetings also discussed health committees' involvement in the District Health Plan. At both meetings, the Department of Health made commitments to engage with communities and ensure sufficient time for community comments on the proposed legislation. At the second meeting the Department of Health committed to developing a consultative process around the legislation. Health committees were vocal in their suggestions on legislation. For instance, they argued strongly for elected[21] health committees and for a tiered structure of community representative structures with health committees constituting the first tier, the second tier being at sub-district level and the third tier at district level.

In July 2015 the Bill was published without prior notification to stakeholders who had been involved in the consultation process. Shortly after, a third community consultative forum was held, continuing the discussions on health committees' involvement in district-level planning and the draft legislation on health committees. Health committee members and other participants raised many concerns about the Bill. There were concerns that despite a promise to involve health committees in the drafting of the Bill, no consultation had taken place. Furthermore, members argued that time for public comments was very short. Health committee members felt that they would not have sufficient time to liaise around a submission. A suggestion was made that the submission period be extended by a month, something that was accommodated.

[21] The argument for elected health committees does not necessarily entail elected by people in the clinics' catchment area. It could refer to organisations electing health committees - as is practiced in many communities.

With regards to the content of the Act, the primary objection raised was that health committee members were to be appointment by the minister rather than being elected by communities. The argument put forward was that appointments meant that health committee members would not be accountable to the communities they reside in and supposedly represent. A second concern related to the roles assigned to health committees, which they felt gave them limited influence. Objections were also raised to the fact that committees can request information, but there is no mention of facilities being obliged to provide said information. Lastly, health committees found that many roles that they would have liked to see in the Bill were missing. These included involvement in budgeting, staff appointments, complaint management, awareness-raising and having oversight over health service delivery. Participants in the meeting also felt that the Bill fell short in not putting in place links between health committees and structures operating at sub-district, district and provincial levels. The Bill also made no reference to provisional recognition of existing committees, an issue discussed at length during the consultation process. Instead, the Bill expected committees to be established from a clean slate. Concerns were raised about lack of resourcing beyond transport reimbursements and no explicit commitment to capacity building through training. Some health committee members were critical of the process and felt that there had been 'very limited engagement'.

The next stage in the consultation process was public submissions. Health committees in Cape Town, through the CMHF, along with a number of other organisations including the Learning Network on Health and Human Rights and the School of Public Health at UCT, made a submission in which they raised many of the issues already emphasised in the consultative discussions. Here, the perceived process flaws were raised, including the fact that there had not been a consultative process prior to the release of the Bill.

The submission highlighted concerns about the appointment of health committees and reiterated that committees should be elected, but also that there should be measures included to ensure diversity. Concerns similar to those raised at the consultative meetings regarding roles were put forward. Moreover, the submission referred to the provincial health Department's strategic plan called *Health Care 2030* (Western Cape Department of Health, 2013), in which the Department commits itself to improve community involvement in the *design* of health services. Based on this, the submission argued for health committees to have

a role in planning health service delivery, contribute to departmental strategy, monitor services, be involved in complaints resolution.

Additionally, the submission highlighted the right of access to information and the importance of capacity building. On the issue of how community participation should be structured, the submission emphasised the need for both vertical and horizontal links – between health committees, but also a tiered system of community participation structures that will ensure that issues raised at health committee level will be articulated at other levels of the health system. The submission ended with a proposal for an extended consultation process, which was granted.

In October and November 2015, the People's Health Movement (PHM), an independent organisation, ran consultative workshops with health committees, during which a facilitator discussed the Bill with health committee members in the Cape Town metropolitan area. Shortly after, in December 2015, health committees marched to the Western Cape Department of Health to demand input in the writing of the Bill. A second version of the Bill was released in March 2016 (Western Cape Department of Health, 2016).

This was followed by another call for public submissions. The Health and Human Rights Programme based at the School of Public Health, University of Cape Town, made a submission, which again lamented the process: the fact that the Department had not instigated a consultative process between the two versions of the Bill, despite a commitment expressed at the consultative meetings. Furthermore, the submission argued that little consideration had been given to the issues raised in the consultative meetings. The submission highlighted two positive changes: firstly, a commitment to training had been included; and secondly, provision for reimbursement of transport costs had been made. Negative changes were also noted in relation to roles, such as the removal of a role to "assist the management of the primary health care facility to identify the priorities of the community and possible strategies to address these priorities" (Western Cape Department of Health, 2016:ss11(9)). The removal of this role limited health committees' roles further. The second negative change highlighted was the inclusion of a role of raising funds for the facility and for the functioning of the committee. The submission argued that this could be seen as an expectation that committees were supposed to be responsible for their own funding.

Finally, the submission noted that a provision for diversity in terms of race, gender, age and disability, which was made for health facility boards, should also be made for health committees. The submission repeated points from the previous submission around the roles of health committees, the appointment process, the absence of linkages between health committees and other structures, and insufficient support for health committees. A public hearing with oral submissions was held in May 2016. Here several submissions were made by stakeholders throughout the province, including the LN and the CMHF. Subsequently, a request to include a clause on diversity of health committee membership was included, but no further changes were made before the Bill was adopted in July 2016.

There are two interesting processes related to the consultation process worth reflecting on. A public discourse around strengthening community input and consulting communities was prevalent during the consultation process, where the provincial Department of Health repeatedly committed itself to consultative processes and to allow sufficient time for community input. Yet these commitments were not followed. Consultative meetings organised by the Department did not take place as promised. Very few suggestions from the consultation process and the submissions resulted in changes in the Act. There was no transparency around decisions made in finalising the Act. The Act was drafted and finalised in a closed policy space and no explanations were given for changes made. Thus, there is a discrepancy between the consultative process and the public rhetoric around consultation and participation. The consultation process allowed health committee members minimal influence in designing the space, despite the 2030 Health Plan's intention of involving communities in designing health services.

Paradoxically, the three consultative meetings around the Act were held in parallel to discussions on how health committees could give input into the provincial health planning process, including the annual planning process and the District Health Plan. This is in stark contrast with the vision for health committee participation in the Act that was under development, which did not envision health committees to have any role in planning. Thus, there seems to be a dissonance between a vision presented around participation and the vision embedded in the Act – between suggestions, on the one hand, of engaging health committees in health system planning, yet on the other hand, limiting their roles in the Act. A similar disconnect is apparent in relation to budgets, where health officials talked about the importance of health committees knowing the budget, yet the Act does not give health

committees any role in budgeting. A possible explanation is that there is confusion around a vision for health committee participation. An alternative interpretation is that there are two discourses around participation: a public discourse of involvement and substantive influence, and the discourse encapsulated in the Act, which puts in place a limited form of participation.

Invited spaces are characterised by authorities inviting citizens to participate. In that sense, invited space are spaces over which authorities have control at the outset. Their power remains entrenched unless the space is negotiated and created to transfer power to other actors. It is difficult to track any real community influence on the creation of the Act, despite the commitments made. The consultation process was at face value a process where communities could have had influence and a space could have been designed that provided health committees with power. Their limited influence and lack of transparency around finalising the Act turned the consultation process into an illusion of consultation.

The consultation process enabled the Department to claim that it had engaged in community consultations, but it became a consultation without influence. It is my contention that the consultation process became a process that at face value created an illusion that communities had been consulted about the Act, echoing the *Powercube*'s claim that the purpose of participation sometimes can be to "give an illusion of participation" (Powercube, 2011:17). I now turn to how members from the urban health committees experienced the process.

5.5 Health committee members' experience of the consultation process

Health committee members' awareness of the Act both during the time it was being drafted and after it was adopted differed in the two committees. Besides the chairperson, members of the rural committee were completely unaware of its existence. In contrast, the majority of members in the urban committee were part of the engagement process outlined above. In addition, the provincial health minister briefed the committees in the urban area and the standing committee on health engaged with that community. Furthermore, through the Upper Structure, they received updates as this structure had a line of communication with the provincial health minister. Some of its members had also attended the training organised by the PHM and a session in the Western Cape legislature on how to make a policy submission. Notwithstanding that many health committee members from other health committees spoke at

the consultation meeting, health committee members from the urban committee did not and they perceived the consultation process to be flawed. They indicated that they had not understood the Act and had not been capacitated properly. Because of this, they had not been able to exert sufficient influence.

Amongst the health committee members in the urban site, there was limited trust in the process. This was linked to a belief that political commitment to health committee participation was lacking. Thus, their engagement was associated with a feeling of disappointment and a sense of being taken advantage of. This was expressed through repeated usage of the words 'being used' – an expression used both in relation to the engagement around the Act, but also more generally in relation to participation. The following comment is illustrative: "These people use us when it suits them. Does not even recognise us," said Beatrice. Nonzwakazi commented in a similar way:

> The MEC is that kind of a person that will move with you. She speaks nicely. If you are not mature mentally, she will fool you and mislead you. She speaks well. … But practically she is scarce. She has promised health committees things, but not delivered. (Nonzwakazi)

Many expressions were used when talking about the engagement process indicating that despite being 'invited', health committee members felt disempowered and unable to fully participate. As the comment below indicates, health committee members felt they had not been listened to sufficiently.

> The Bill is passed as an Act. There will be something. We were heard, but as we are not advanced … those that are the winning team are those that are advanced. We were new in this debate. There are things we raised. Not sure whether we should have raised them. Other organisations raised issues that were more considered … We were heard, but not as much as other people. (Nkosi)

Instead, there was a general feeling of powerlessness. The health committee members, who had attended training, felt that it had not equipped them sufficiently, because it was conducted at a level where health committee members were left behind.

> We were mixed with NGOs, with people that are advanced with knowledge. We did not have the knowledge that we have now [after discussing the Act during focus groups]; that is why we said if we had had that earlier we would have been better at discussing issues. We were not well prepared. Members from TAC, MSAT[22] and PHM understand it better. They have strategies. We should have voiced better. There were organisations that were supporting us, but we were just there singing along. That made the Department take advantage over us. (Nkosi)

Health committee members tended to personalise the issue of the Department's approach around the figure of the MEC. They felt that she should have consulted more with community structures before putting the Act through parliament. "Before she was elected to be MEC, she knew there were structures, but she failed to consult those structures. She proposed her own policy without consulting properly with structures she was aware of," argued Yeliswa. Another member expressed this in the following way:

> Whoever was busy formulating the Act, never went all out to get the views of community members of how these committees work and the boards [referring to health facility boards]. Whoever wrote the Act, it was someone who never did her research in terms of how communities work and how community structures work and how can they work in the government sphere. (Beatrice)

Health committee members attributed their limited influence to not having sufficient knowledge and capacity to participate in the consultation process. This serves as a reminder that creating spaces for participation is not enough, if those invited are not able to participate, as noted in the *Powercube*. Rather, creating spaces that are participatory in nature, but that do not facilitate participation, can be viewed as a form of hidden power, because there is engagement without influence. Health committee members' reflections on not having sufficient skills and capacity indicate that skills and capacity operate as a form of hidden power impacting on their agency and preventing them from having influence.

The public rhetoric about community engagement was in stark contrast to the lived experience of the consultation process, which was experienced as disempowering because

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22 MSAT stands for Multi-Sectoral Action Team.

hidden forms of powers undermined health committees' influence. It gave an illusion of consultation and participation, but in terms of influence, transparency and accountability it was a process that was described in the words of one health committee member as a process that simply 'ticked the boxes': "They just wanted to do the consultation to tick the boxes, but it was not what was proposed by most of the stakeholders," said Nonzwakazi. This resonates with Cornwall's (2002) assertion that invited spaces are framed by those who create the space. The invited space was then, in many respects, a space experienced as disempowering and led to questioning the Department's commitment to participation.

As noted by democratic theorists such as Pateman, participatory democracy assumes that participants experience a degree of control and because of that trust the process irrespective of the outcome: "Subsidiary hypotheses about participation are that it has an integrative effect and that it aids the acceptance of collective decisions," (Pateman, 1970:43). In this case, participants had limited control and the process did not generate trust or acceptance because of the lack of transparency and accountability.[23]

Though there are many constraining aspects of power in the Act, it is important to note that health committee members did not internalise these but displayed critical awareness of them. They drew on alternative discourses such as a rights discourse as a form of enabling power to argue for more expansive roles. Sibongile, for instance, believed that the urban health committee's role was to ensure rights. Laurie believed that knowing their rights would enable the health committee to hold the government accountable. The concept of rights was also evoked by Elise when she addressed problems at the rural clinic.

There are two theoretical positions worth considering in relation to the consultation process. The first is the *Powercube*'s understanding of invisible power as internalised beliefs. The second is Scott's argument that people do not necessarily internalise dominant beliefs. The critical voices around the consultation process could then be viewed as evidence that health committees did not accept the consultation process as a genuine form of engagement and did not internalise the health service actors' view on the participatory consultation process or the content of the Act. Hence, they cannot be said to have internalised these beliefs or the

[23] In this context I understand accountability as meaning 'answerability' – that explanations were given for decisions made and how comments were dealt with.

'rhetoric of participatory engagement'. Instead, they felt disempowered. Several telling metaphors speak to this. The examples of 'singing along' and Beatrice's assertion that "If the Department says dance, Health committees must dance" are illustrative of unequal power relations. Hence, while lack of capacity and knowledge functioned as a form of internalised power, beliefs did not.

The invited space created with the Act was thus an ambiguous, contested and unstable space because there is not agreement on what participation entails. This resulted in discussions about attempting to change the Act, as I will explore in the next section.

5.6 To object to or accept the Act

Discussions about the Act often resulted in health committee members proceeding with deliberations on taking action to have the content changed. These were more pronounced in the urban health committee, where lengthy discussions on what to do ensued. Suggestions of asking the Upper Structure to intervene or contacting the MEC to ask for clarification and explain how the Act was going to be implemented followed, as illustrated in the quote below:

> We need to challenge the Department even though the Act has passed. We can't have an Act which says you may do certain things. The Act needs to be revisited, especially where we see gaps. (Yeliswa)

During one such discussion, however, all suggestions were dismissed by a health committee member (Nonzwakazi) with the following sentence: "Let's just accept what we have." Interestingly, other health committee members agreed – the discussion stopped, and silence followed. The health committee seemed to resign itself to accepting that there was no point in making any attempts at changing the Act.

The urban health committee never addressed the issue with the Upper Structure, neither did they call the minister or the facility manager. At times suggestions of 'doing something' resurfaced, but in the end their acceptance of the Act prevailed. They seemed to acknowledge that changes were not possible. This acknowledgement was linked to a feeling of disempowerment, as reflected in Yeliswa's quote below.

> It is a pity that we never had an opportunity to be mentored when the Act was a Bill. We never engaged or understood. If only we had had enough time to be workshopped and trained, maybe we could have made a contribution. (Yeliswa)

The urban committee's decision not to take any action may seem puzzling, given their views. So why did they decide not to attempt to change the Act despite their discussions on taking action? Two different views of power described previously are useful here. Lukes's third face and the *Powercube*'s invisible power suggest that internalised beliefs prevent actors from expressing agency. Haugaard further adds an understanding to this form of power by suggesting that these beliefs are created from a process of structuration and confirming these structurations. Through this process beliefs are internalised. This internalisation can be viewed, for instance, through an understanding of one's "place in the world" (Gaventa, 2006:29) or beliefs in "how things are done" (Haugaard, 2003:95). An alternative explanation can be derived from considering Scott's theory. He argues that it is not internalisation that leads people not to act. It is a strategic choice. Their resistance is channelled towards a 'hidden transcript' rather than being uttered in 'public'. Furthermore, Scott (1990) talks about 'thin false consciousness', which basically is a theory of resignation. According to this theory, people resign themselves to certain conditions not because of internalised beliefs, but because they see no alternatives. The question these theories raise is: does the urban health committee decide not to take action on the Act because of internalised beliefs or because of resignation and deferred resistance?

It is evident that internalised beliefs are not the primary reason for the urban health committee's inaction. There was no confirm-structuration taking place of the official view of participation. Health committee members expressed their views on the Act in the research process and in meetings where only health committee members were present. Their reluctance to take the matter up with the MEC or to raise it with the facility manager could be seen as a reluctance to utter their disapproval in a more public forum. Though their resistance is not moved to a hidden space, it is not transposed to a fully public forum either. Health committees may at this stage not feel ready to confront health system actors (either in the form of the MEC or the facility manager) or raise their objections, but they are articulating their opinions, be it in the safe space of their committees or during research activities. This could be viewed as form of 'practice'. That they finally decide not to take any actions can, in my view, be understood both as them not being ready, but it can also be understood as a form

of resignation, evident in expressions such as 'let's just work with what we have'. It is a resignation that is not based on agreement with powerholders on the Act, but a conscious decision made because they view their options of influencing change as non-existent.

To what extent their decision was also influenced by their experience with their limited influence in the consultation process – the experience of not being heard – is also worth considering. Similarly, their experience of the training they had received on the Act had to some extent been disempowering. Thus 'their understanding of their place in the world' – to reference Gaventa – may be one of limited influence, which sometimes leads to resignation. Continuing discontent with the Act can be viewed as further evidence that their decision to accept the Act was not linked to internalised beliefs.

Furthermore, I argue that the divergent views on participation expressed through views on the Act can be viewed as a 'failed' confirm-structuration process. Health committee members are not confirm-structurating the beliefs around participation inherent in the Act. This means that their decision on how to engage with the Act remains unsettled and, as I will later show, resurfaces and lead to other considerations. The fact that health committees later explored other avenues for changing the conditions for their participation also provides evidence that their decision was not a result of internalised beliefs. Chapter 8 illustrates how their understanding of the constraining conditions of the invited space resulted in them exploring other spaces.

5.7 Conclusion: what kind of space is the invited space?

This chapter began with a description of a meeting where the provincial minister announced that with the impending legislation, health committees would get power through being appointed by her. I contend that the Act gives health committees a mandate and through this countervailing power, but simultaneously the Act constrains participation and erodes committees' countervailing power in several ways through direct visible as well as hidden forms of power. These include: 1) a system for appointment which gives the provincial health minister the power to decide health committee membership; 2) roles that are limited in terms of health committees' decision-making power; 3) influence is restricted to the lower level of health system; and 4) limited support for participation.

Together the Act and the consultation process gave an illusion of providing power to health committees, but at the same time other forms of power constrained them. Health committees had limited influence in designing the participatory space. I have also argued that they did not internalise the view that actors from the health services presented of the consultation process or their view of participation, but rather objected in the 'hidden' space of their committee and the research setting. Health committees' critical reflections on the Act as well as their insistence on their rights showed that they employed forms of enabling powers in their engagement with the Act: a critical consciousness and a perception of themselves as rights-claiming citizens.

I posited that the Act conceptualises participation as a privilege rather than a right, making participation contingent on the goodwill of the health services. This contributed to the creation of an invited space that is a contested, ambiguous, unstable space with limited countervailing power and opportunities for influence. Because there is no agreement on what constitutes health committee participation between those who created the space and those who are invited to participate, there is continued contestation around the Act.

The chapter argued that health committees' experience with and understanding of the invited space has led to a dilemma around whether to accept the Act or attempt to influence changes. Though health committees currently engage with the newly created invited health committee space and explore its possibilities, they are simultaneously aware of and concerned about its constraints.

6 "I can't represent myself": challenges to health committees' legitimacy

6.1 Introduction: the march to the urban facility

The urban health committee is gathered for a meeting in the clinic's boardroom when a member raises what he calls an urgent issue. The facility manager has received a letter from the regional South African Communist Party (SACP), informing the facility that the party has planned a march to the facility, where they intend to hand over a memorandum concerning poor service delivery. A survey conducted by the SACP about service delivery is supposed to support these claims. Members from the committee have attempted to engage with the party, wanting clarity on the issues raised in an attempt to stop the march, but the SACP has not been willing to enter into discussions before the march.

A long discussion on how to stop the march follows. "The protest is not OK until we know what it is about. We must stop the protest," argues Sipho. His view is supported by many. Reasons given include that there should be engagement between the clinic, the health committee and the SACP first. There are concerns that services will be disrupted. Some are convinced that a political agenda is driving the SACP or that the party's actions are fuelled by the fact that an SACP member passed away at the clinic after a stabbing incident. There are discussions on what to do. "We are not going to allow you [the SACP] to destroy services being rendered at the clinic. We are the leaders in this community," argues Beatrice. However, not all health committee members approach the impending march with the same agitation. Nkosi is a lone voice, when he calmly comments: "I have a totally different view. Let them come and march. Then we will engage and do a follow-up with what they are raising," he argues.

The following weeks are unusually busy. Meetings with attendance of the facility manager, the Upper Structure chairperson and managers from the health sub-district follow. It is the first time almost a year into my fieldwork period where these stakeholders get together, clearly indicating the significance of this event. A letter is written from the health committee to the SACP. The letter states that the SACP's concerns are incorrect. Furthermore, it alerts the SACP to the fact that there is a health committee at the clinic that deals with patients' complaints, and that the facility manager is also open to discuss concerns about service delivery. The committee feels undermined by the SACP and disappointed by its actions, it

says. However, engagement with the SACP fails and on an August morning, a full board room readies itself to meet the protesters. As final preparations are being made, a security guard rushes to the room, informing them that the march has arrived at the facility's security gate.

Red flags and banners with Che Guevara are held by a group of SACP members and community members, who await the clinic's delegation. The regional chairperson of the SACP reads out the memorandum, highlighting the service delivery issues. The issues raised in the memorandum are complaints that are familiar in public health clinics in South Africa – long waiting queues, staff attitude, medicine stock-outs in addition to some specific issues of poor treatment of patients. But what upsets the health committee members most is a charge that the health committee is dysfunctional, not known in the community, does not give feedback to the community and is ineffective in representing the community. The memorandum is handed over to representatives from the sub-district, and the Upper Structure chairperson responds to the SACP.

Back in the boardroom after the march, there is relief that calm prevailed. People also comment that they perceive the size of the march to be small. But it is also time for reflection. The allegation that the health committee is not well known and does not provide feedback to the community has hit a nerve. The committee and facility management concede that they have not been good at giving feedback to the community and a decision is taken to organise a health imbizo (colloquial term for a large meeting/gathering) where both the facility and the health committee will engage with the community. Later, the facility's response to the SACP's claims are discussed at length and a decision is taken to engage with the SACP around the issues they have raised. While most issues are dismissed, the facility management concurs that waiting time, averaging five hours, needs to be addressed.

The SACP march highlights a number of issues relating to health committee participation. Firstly, it questions the extent to which the committee is viewed as representing the community. Secondly, it contests the effectiveness of the health committee in ensuring service delivery. Linked to this, the SACP indirectly – by engaging in protest rather than engaging with the health committee – proposes that the participatory model embraced by the health committee is ineffectual compared to the mobilisation-protest model employed by the

SACP. In short: the health committee's instrumental and substantial legitimacy is challenged.

The previous chapter argued that the Act did not provide for an invited space with sufficient countervailing power. This chapter explores the current model for forming health committees and the extent to which it provides sufficient countervailing power. I begin by exploring how the health committees claim legitimacy through their claim to represent their communities. I then examine the urban committee's claim to be an accountable structure. Lastly, I examine their claim to effectively address the community's needs. The next section discusses how the challenges to health committees' legitimacy impact on their countervailing power. The final section discusses how other sources of countervailing power could potentially be generated. In doing so, it discusses whether strengthening links with community structures that employ more confrontational tactics could be considered a possible avenue to generate countervailing power.

6.2 Claims of representivity and having a community mandate

6.2.1 Weak relationship with communities in the urban committee

In the previous chapter I showed that health committees' opposition to appointed participation was based on an argument that appointed participatory structures are not truly representative of communities. The model favoured by health committees is that of an organisational model or stakeholder model, where organisational representatives or stakeholders from the community become health committee members. Representatives are elected by organisations to represent them. Health committees argue that their mandate and hence their legitimacy comes from them representing communities. They claim to be legitimate structures because they represent and get their mandate from communities, which provide them with a potential source of countervailing power. However, in both communities there were challenges to health committees' claim to representivity and, linked to this, their legitimacy. This, in turn, also impacted on their countervailing power.

The urban health committee's claim to be a legitimate structure representing the community was further challenged in the weeks following the SACP march. An article in a local community newspaper articulated the SACP's claims of weak links between the health

committee and the community. It claimed that the health committee was unknown in the community and did not hold feedback meetings. Subsequently, community members began to question health committee members: “Ever since that article [the newspaper article] was published, health committee members’ morale came down. Some community members are asking us: ‘every day you are going around and doing nothing,’” commented Nonzwakazi. Before “people would speak with confidence that they know there is a health committee that is doing wonders. Now some people are witnessing this happen and are saying: you are doing nothing,” explained Beatrice. The SACP march resulted in community members complaining to the health committee that it was dysfunctional. Other health committee members argued that community members recognised them as health committee members, but because the community is big, it should not be expected that everybody knows of the health committee.

There were also other examples of the health committee not being visible in the community. At a project funded by the Global Fund, representatives from the South African National Civic Organisation (SANCO), traditional healers and ward councillors put forward similar claims. Furthermore, during the research period I spoke to many community organisations that did not know of the health committee. For instance, a social worker (Noxolo) from a children’s organisation, who came to the clinic frequently with the children, said she had never known of a health committee, but would have liked to collaborate with it. Other organisations, including organisation focusing on children and specific patient groups, were also unaware of the committee.

These challenges suggest that the urban health committee struggled to be visible in the community and there were groups in the community that did not feel represented by the health committee. The urban health committee was aware of the issues and believed it could be solved by having their names displayed in the clinic and having name tags and t-shirts that would make them recognisable. Throughout the research period they attempted to address this, but to no avail. Interestingly, they focused more on enhancing visibility through name tags than through strengthening feedback meetings.

6.2.2 Community disengagement in the rural committee

The rural health committee members also struggled with visibility in the community and being viewed as a representative structure, though their difficulty was of a different nature than the urban committee's challenge. Like the urban committee, the rural committee favoured the organisational or stakeholder model, but had not been able to form a health committee based on that model. The reason for this was lack of interest amongst stakeholders and the community. The health committee noted that many stakeholders viewed the committee as a talk shop, a structure with little impact. Attempts were made to engage a number of stakeholders to set up a health committee, but when they showed no interest, a small group of individuals formed the committee. This community disengagement challenged the committee's claim to represent the community and have a community mandate. In turn, this eroded the committee's power.

The committee was fully cognizant of this and lamented it, but was unsuccessful in addressing stakeholder disengagement, something that both the committee and the facility manager identified as one of the biggest problems for the committee. Hence, the committee members viewed the health committee as a 'group of individuals' who wanted to represent the community. However, the chairperson argued they couldn't really claim to represent the community, because they did not have a mandate from a community organisation. He said that for the committee to be properly constituted, individual members should have a written mandate from a community organisation. Otherwise they become a group of individuals with no mandate. "I can't represent myself. And that is a trend. That makes it extremely difficult. I must have a written mandate (from an organisation)," said the chairperson. On a similar note, another member, Elise, said that the health committee would have a stronger mandate if its relationship with the community was strengthened. The facility manager's attitude to the committee is illustrative of how the health committee's countervailing power was eroded by the weak links between the committee and the community. The manager argued that she found the committee 'useless' – her word – without the relevant stakeholders.

Having explored how the poor links to communities represented a challenge, I turn to exploring how the formation process also constituted a challenge in the following section.

6.2.3 Formation of health committees

In both communities, the process of forming health committees was led by community leaders, who decided who should be invited to form health committees. The urban health committee was elected at an elective annual general meeting to which a group of organisations or stakeholders were invited. The organisations were identified by the Upper Structure in collaboration with civic organisations and local government councillors. Organisations sent two representatives to the meeting. These representatives could nominate representatives, be elected and vote for the 13 health committee members. About 80 people out of a population of 100,000 attended the meeting.

As noted, the rural committee was unable to implement the stakeholder model. Though the rural committee saw itself as interim and wanted to form a committee based on the stakeholder model, no initiatives towards this were forthcoming during the research period

In both cases the rationale for stakeholder representation was that sectors/organisations with an interest in health or organisations that could be considered to represent communities should be involved. In the urban committee representatives for traditional healers and SANCO were viewed as important members.

There are several implications for health committees' legitimacy and representivity related to this formation process. Firstly, the process sets boundaries for who can become a representative and who cannot. In the organisational or stakeholder model only people representing organisations or stakeholders can become part of a health committee, thus limiting membership to organised parts of the communities. This raises the question of the extent to which a model where only organised sectors are invited can ensure inclusive representation. Secondly, the process of identifying organisations is carried out through a process of invitation. By omitting organisations – irrespective of whether omissions are deliberate or not – the process becomes exclusive rather than inclusive.

I also came into contact with several organisations in the urban area that had not been aware of the elective annual general meeting (AGM) where the health committee was elected. While they did not feel they had been deliberately excluded, they indicated that they would have liked to be part of forming the health committee. These included school governing

bodies, churches, youth organisations, TB/HIV organisations and homebased carers. This did not always mean that they felt that the committee did not represent their views. For instance, Phumeza, a young woman representing homebased carers, was content with the health committee even though her organisation did not attend the AGM and was not represented. She argued that the committee was instrumental in improving service delivery and represents the community well: "They [the health committee] is very much encouraging the community, especially around TB and defaulters. The health committee will help in assisting in identifying them. (They) also encourage the community to test. They play a vital role," said Phumeza.

Hence, in both committees a relatively small group identified organisations or stakeholders to be invited to form committees. This points to a relatively closed process, where few people controlled who was invited to form the committee. It is evident that this form of formation process gives power to those who decide who are legitimate to be invited, to become the electorate and to be elected as representative.

In both committees the processes to establish committees pose questions around how representative health committees are. Another issue which challenge their claims to representivity and legitimacy is the composition of health committees, which I address in the following section.

6.2.4 Composition: 'Giving voice to those not normally heard'?

Urban health committee members viewed the issue of who they represent in three ways. They primarily considered themselves as representing the entire community. In addition, they also considered themselves representing the organisations that they formally were elected to represent. Lastly, health committee members also spoke about representing certain interests and groups. Those were groups whose interests they would like to take up. The rural health committee viewed themselves as representing the community and groups they would like to speak for.

One of the considered benefits of participation is that it gives a voice to people not normally heard and thus broadens democracy (see Head, 2007; Hilmer, 2010). Whether health

committees do give voice to marginalised is dependent on their composition – on how diverse and inclusive they are. By diversity, I refer to including a range of different segments or types of people. By inclusion, I refer to an intention to include people who may otherwise be excluded or marginalised.[24]

In the Act diversity and inclusivity are included as principles in a section saying that the MEC must pay attention to age, gender, race and disability (*Western Cape Health Facility Boards and Committees Act 2016*, 2016:ss6(7)). In practice there was limited consideration to inclusivity and diversity in composing health committees. To the extent that the committees were diverse and inclusive, this was more a result of chance than of deliberate design. A reason for this could be that the stakeholder model can be said to favour, by design, organised structures.

In terms of gender parity, the urban health committee had relative gender parity with six women and four men. The committee had a considerable number of young and middle-aged people. There were no elderly people, with the oldest being 53. The urban health committee is situated in an isiXhosa-speaking African township, which was reflected in its membership in that all members belonged to this population group. Lastly, there were no disabled persons represented, something one of the members pointed out as an issue that should be addressed.

The rural committee had two male members and four female members (an over-representation of females) and consisted mainly of middle-aged people, with the youngest being 42 and the eldest 61. There is not available data on the percentage of the different racial groups using the health facility in the area. However, in the 2011 census just over half were registered as Coloured, while approximately 40 % were registered as Blacks and 6 % Whites. Two percent were registered as "Other" or Asian/Indian."

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[24] The definition of diversity is based on Merriam-Webster online dictionaries: "the condition of having or being composed of differing elements**:** Variety, *especially***:** the inclusion of different types of people (such as people of different races or cultures) in a group or organization."

The definition of inclusivity is based on Oxford Online Dictionaries: "The practice or policy of including people who might otherwise be excluded or marginalised, such as those who have physical or mental disabilities and members of minority groups."
Available at en.oxforddictionaires.com and Merriam-Webster.Com

Despite the substantial Black population, all health committee members were Coloureds. That Whites were not represented is likely to reflect the link between socio-economic status and the use of public facilities, as South Africans in the middle- and upper-income brackets generally make use of private health facilities. When asked about lack of Black representatives, the chairperson explained that there was no deliberate attempt to exclude them and that attempts would be made to engage with this population to ensure their representation on the committee. However, this did not happen during the course of this research. Nevertheless, the committee did become more representative in terms of racial categories as a woman presenting herself as representing the indigenous Khoi population (the Griqua) joined the committee at the following meeting.

The two health committees shared an important view around representation: the inclusion of practitioners of traditional healing systems. The urban health committee had one traditional healer (African). In addition, a young male member said he represented traditional healers though he was not a traditional healer himself but was connected to their organisation. In the rural committee a traditional healer representing the Khoi joined the committee during the course of the research. Other stakeholders represented in the urban committee included youth organisations, a food garden project and several members representing SANCO, South Africa's largest civic organisation with approximately 6 million members established in 1992. SANCO has links to the governing party, the African National Congress. In addition, there was a member who represented COMCO (Community Civic Organisation), a civic organisation aligned with another political party, the Congress of the People.

Neither committee had clear principles guiding health committee composition, though the urban health committee said that health committees in the sub-district tend to have at least representation from SANCO and from traditional healers. The rural committee explained that they would like farm workers, crèches, hospital boards, social welfare, a local hospice, ambulance services, churches and police to be part of the committee, but the committee was not based on representational links.

A striking feature of the composition of the urban committee was that many people claimed to represent or were affiliated to SANCO. When asked what this meant for their health committee membership, they argued that being a member of SANCO had no significance. Being a member of SANCO was viewed as part of residing in the area. "SANCO is a

strategic reporting platform, because you get everybody in the community via SANCO," explained Nkosi. SANCO membership was simply associated with representing the community. The link to SANCO points to the fact that community structures may capture participation when there are no clear procedures for establishing health committees. Furthermore, it is important to bear in mind that SANCO has been argued to be the African National Congress's little brother (Piper, 2015). The health committee's association with SANCO only came up directly once, namely in relation to the SACP march, where members could not understand how the SACP[25] could protest against the clinic, since the party is aligned to the ANC as was the health committee via SANCO membership. The importance of SANCO dominance may suggest that health committees in this area were to some extent monopolised by ANC-aligned members. Many members were in fact card-carrying members of the governing party. This suggests complex relations between party politics and participatory politics. It also questions the extent to which participation is an alternative to traditional political spaces.

A study on informal politics in a Cape Town township (Piper, 2015) argues that "one of the reasons for poor local governance in South Africa is the closing down of independent citizen voice, action and organisation at the most local level in South Africa" (Piper, 2015:36). The author linked this to SANCO and ANC-aligned activists monopolising the space. SANCO dominance in the urban health committee could be viewed in a similar way, as a place that becomes an extension of the state rather than a way of broadening citizenship.

There was also limited consideration to including marginalised groups. Urban health committee members viewed the question of representation as an issue around who they felt they represented, referring to groups for whom they would like to speak. Here groups normally perceived to be marginalised such as the elderly, women and children were mentioned frequently. Yet other groups normally considered to have difficulties in accessing health care such as refugees, the disabled, and the LGBT population (Swartz, 1992; Human Rights Watch, 2009; World Health Organization & World Bank, 2011; Haricharan et al., 2013; Muller, 2017) were not mentioned. Neither were specific patient groups such as HIV-positive or patients with chronic illnesses.

[25] The SACP is in an alliance with the governing party, the ANC, and the Congress of South African Trade Unions (COSATU), South Africa's biggest federation of trade unions.

Despite arguing to represent specific groups either formally (such as traditional healers) or informally in the sense of speaking on behalf of (such as the elderly or children), there were no instances during the fieldwork period where such representation translated into taking issues up on behalf of these groups. The traditional healers, for instance, did not discuss issues of how the facilities collaborated with traditional healers or not. Issues around youths' access to health services were not brought forward by those arguing that they represented the youth. Thus, there is no clear picture that representing a specific group meant that they spoke on their behalf or, conversely, that they neglected other groups. When observing who they talked for and acted on behalf of, it was clear that representation was most strongly linked to representing anybody in the community. This could, in the case of the urban committee, be linked to the fact that their primary function was to deal with complaints and monitor service delivery. In those capacities, they took up issues that were presented to them irrespective of who they identified as representing.

Overall, the composition of health committees is neither diverse nor inclusive. This challenges health committees' claim to representivity and legitimacy. These claims were also linked to claims of being accountable to communities, which I will reflect on in the following section.

6.3 Lack of accountability and feedback

The urban committee's preference for the organisational model rested on an argument that health committee members were accountable to the community organisations they represented and gave feedback to them and via them to the community. However, the SACP complained that these feedback meetings did not take place, a problem that was acknowledged by the committee. At the outset of the research period feedback was described as something that was ongoing. Yet during the fieldwork period no feedback was seen to have taken place. When I asked about attending these feedback meetings, participants told me they were not happening. It is unclear whether they had taken place at all or just stopped. At first, I was told that feedback meetings were going to happen. Then I was given explanations for why feedback meetings were not taking place: many health committee members represented SANCO and it was difficult to decide which SANCO branch to report to; for the

youth organisation it was challenging setting up meetings; and meetings at night posed a security risk. Subsequently, the health committee argued that they wanted to change the way they gave feedback to the community. When I asked months later, they argued that they had decided to organise a feedback meeting with the facility, so the facility could also give feedback to the community. But the plans did not materialise. The committee and the facility only decided to organise a health imbizo to give feedback to the community when the health committee's legitimacy was challenged by the SACP. The health committee considered this imbizo successful and decided that they would use such imbizos in the future to give feedback. A year later another imbizo was held in collaboration with the Department of Health and the facility.

The issues described above are not meant to suggest that the urban committee did not engage with the community, but rather that formal feedback did not take place. Informal feedback and engagement took place in different forms, for instance, when the committee collected patients' complaints from complaint boxes. Health committee members spent time at the clinic monitoring service delivery and engaging with patients. At health committee meetings members would bring forward issues related to patients' experiences which they had come across in the community. It was evident that community members in the urban site would contact the health committee and ask it to address certain issues, indicating that there were community members who recognised the committee as a legitimate structure. However, since the urban health committee claimed its legitimacy from the formal accountability measures, not having formal mechanisms impacted on the committees' legitimacy.

The rural committee faced similar issues with regards to accountability. Given that the rural committee was not based on a stakeholder/organisational model, there were no claims about giving feedback directly through meetings. Though members claimed that the population knew of the health committee, the health committee was aware that lack of feedback meetings undermined its legitimacy, leading Elise to argue that "it is high time we introduce ourselves to the community." Thus, both committees valorised the importance of community feedback meetings, as they believed this would strengthen their relationship with the community and their mandate as community representatives.

In the sections above, I argued that the SACP march challenged the urban health committee's claim to be a legitimate structure through their claim to representivity and accountability.

Below I describe another claim: namely that the health committee was ineffective. Where the first challenge relates to the health committee's substantive legitimacy, this claim relates to its instrumental legitimacy.

6.4 Invited spaces as ineffective

The SACP claimed that the urban health committee was ineffective in addressing service delivery at the clinic. At the same time, the SACP's march represented an alternative form of engagement. By staging the protest, the SACP indirectly made a claim that this form of engagement was more likely to result in improvements than invited health committee participation. The concerns raised – whether legitimate or not – were given little consideration by the health committee. Rather, the committee galvanised its energy around averting the march and defending the clinic against a disruptive protest. In the process, they cemented their own commitment to engagement.

The protest model of engagement is well known in South Africa, both pre- and post-apartheid, and co-exists with the participatory model, which health committees represent. The urban health committee situated itself within an understanding of participation that is congruent with viewing such committees as invited participatory spaces.

The committee rejected the SACP march as a form of disruptive protest, a failure to 'engage constructively', resulting in destroying services rendered at the clinic. The urban health committee's strong objection to the march should be viewed as a rejection of this form of engagement and a defence of their model of invited participation. In their rejection of the SACP march, the health committee also made a claim to be genuine community leaders and community representatives:

> We are not against the march. We are doing our role as the health committee by providing leadership and seeking clarity on the purpose of the march. If what the SACP is saying is correct, then we will join them because we are from the same community, and we are leading the community. (Sipho)

The health committee's collaborative approach to participation also translated into a strong affiliation with the local clinic. "We can't just protest and demand without engaging. How do

we go about engaging rather than destabilising?" asked Yeliswa. There was a strong belief in the urban committee that engagement and collaboration could help solve health service issues. "Engagement will solve things. We need them, and they need us," as Nkosi argued.

It was not only in relation to the SACP that the urban health committee positioned itself as an invited collaborative space. More frequently this was articulated in relation to the Treatment Action Campaign (TAC). The health committee associated this organisation with protests and disruption and characterised TAC members as being 'paid to make noise' and 'toyi-toyi' (colloquial term for protest). Committee members would often talk about how the TAC would come to the clinic and protest and cause disruption. "We are not on the same page as the TAC. Our vision for participation is to render services. We engage government. We don't go and protest. We believe in engagement … Government is us. We are the government," said Nonzwakazi. The health committee reported clashes with the TAC, particularly around protest action. There was an ongoing tense and confrontational relationship with the organisation in the entire sub-district, where TAC members had been elected to some health committees but had left these committees. This also happened in the urban committee, though the TAC member who left the committee did so to take up paid work, which made him unavailable during daytime when meetings were held.

The TAC made similar claims as the SACP: that the health committee was invisible, did not represent the community well and was ineffective in carrying out its mandate. "If health committees were visible and doing their work and having communication with the Department, it would not be a problem. If patients came to the clinic and knew how to complain [it would be better]," said Lara Ndlovu, a TAC representative. Asserting that the health committee was ineffective, the TAC carried out their own form of participatory action at the clinic, involving two core functions also carried out by the urban health committee: namely complaint management in the HIV treatment centre, and monitoring at the clinic.

At the core of the relationship between the TAC and the SACP on one side and the health committee on the other side are different models for engaging with the state and the health services. The underlying assumption in the engagement model is that of a responsive[26] state,

[26] I use the word responsive in its broad sense, not as a term linked to health systems research.

whereas the underlying assumption in the protest model is that the state will only respond to claims made through protest and mobilisation.

In the rural health committee participation and protest were seen much more as a continuum, different options to achieve the same goals. While the committee believed and preferred engagement, protests were seen as an option when engagement failed. The rural committee did not advocate protest as a possible solution but would talk in a more radical voice arguing that 'trouble is coming' and 'trouble is brewing'. There were arguments for a more 'robust approach'. Yet trouble did not come. The rural committee continued to prescribe to the engagement model, but also felt that the community was on the brink of erupting. The community had experienced widespread protests in 2012. The area had also witnessed several protests around issues related to health services, and the health committee felt that protests might erupt again. Elise elaborated:

> There is a feeling. People are getting angry. They want to picket and toyi-toyi at the clinic…. People are very angry. It is like in 2012. Hanne, I put it to you that people on the higher-level think things are smooth, but they don't see the cracks. It is boiling. It doesn't go to the relevant people. But patients are at boiling point.

Like the urban committee, the rural committee's effectiveness was also indirectly challenged. This challenge came from an organisation advocating for farmworkers' rights. The organisation felt that health committees in rural areas in general did not represent female farmworkers' interests. As a consequence, the organisation decided to initiate a project where they have their own monitors at the clinics in neighbouring towns. The project had not started in the rural research site, but local members of the organisation monitored service delivery at the clinic independent of the health committee. On a few occasions they also attended health committee meetings and talked about a stronger collaboration with the committee. The farmworker organisation – like TAC – performed similar functions to the health committee.

Thus, in both communities there were organisations that carried out similar roles as the health committees. They challenged health committees' instrumental legitimacy both directly and indirectly. By doing so, they also challenged health committees' claim to be the body that legitimately represented communities.

Up to this point I have argued that health committees' legitimacy was challenged through questions about how representative, accountable and effective they are. This has implications for their countervailing power, something I will explore in relation to different models of forming health committees below.

6.5 Countervailing power in different models

There are three models for forming health committees in South African policy and practice. These three models are also linked to different forms of legitimacy and countervailing power. In the appointed model envisioned by the Act, health committees' legitimacy is linked to the MEC and they get their countervailing power from the Act, irrespective of my argument that other forms of power make it a weak form of countervailing power. The self-appointed model practised in the rural committee made it difficult to claim legitimacy because the committee could not claim to represent community organisations. Hence, it had very little countervailing power. This resulted in the committee having very little influence because the facility manager did not see any value in the committee, as the following quote suggests:

> In the current health committee, I can raise my issues, but the stakeholders are not there. It [the health committee] is useless for me. I can talk to them. But they [the committee] cannot resolve issues or give any answers. I go to meetings, but not much come of it and I say so. There are so many issues I need to raise. But without stakeholders there is no point. (Rural facility manager)

In the organisational model, practised in the urban committee, the health committee claimed legitimacy from representing community organisations and being accountable to them. The claim to a community mandate can be considered as a form of potential countervailing power. Hence, when this claim is challenged, so is the health committee's countervailing power, leaving them without the necessary power to participate effectively.

The extent to which health committees can draw on having a community mandate as its source of countervailing power then rests on its link with the community and how this community organises to provide this power. Ensuring strong representational links and an inclusive process for establishing committees could help provide more countervailing power.

Paying attention to principles of diversity and inclusivity would also be important. Finally, strengthening formal feedback mechanisms would strengthen their countervailing power.

6.6 Potential sources of countervailing power

The section above ended with reflections on how the urban health committee could strengthen its countervailing power through strengthening links with the community. Here, I consider alternative ways of generating countervailing power.

According to Fung and Wright (2003c), there is limited evidence on the sources of collaborative countervailing power. The authors argue that countervailing power is more common in the adversarial form, but this form cannot easily be transformed into collaborative countervailing power – at least not at national level. One of the reasons for this is that each requires different skills sets and has different cognitive frames. Fung and Wright (2003c) concede that local forms of adversarial countervailing power can possibly be transformed to collaborative countervailing power as they may more easily shift from these cognitive frames. In this context, it would be worth looking at two structures that can be considered adversarial in nature, namely the TAC and the SACP.

In the urban health committee's retelling of their tense relationship with the TAC, it was evident that they represent two different cognitive frames, with the health committee framing participation as collaboration and engagement. In contrast, they perceived the TAC to be using adversarial cognitive frames and strategies such as mass mobilisation and protests. Similarly, the SACP's march was framed in adversarial terms and based on adversarial tactics such as protests.

However, during the research there were also examples where individual local TAC members engaged with the urban health committee. The TAC member, who had to resign from the health committee, considered there to be no obstacles to the TAC and the health committee working together. Similarly, a TAC monitor at the clinic considered joining the health committee and attended some meetings towards the end of the fieldwork period. When nominations to health committees were being considered during the implementation process of the Act, the Upper Structure considered suggesting the regional SACP chairperson, who

had organised the march. The SACP chairperson also talked about a willingness to engage, viewing the health committee as a structure they could work with and 'make have teeth,' as he expressed it.

All of this suggests that the possibility for collaboration exists. This also means that adversarial countervailing power could be transferred to the collaborative health committee space. This may indicate that different mental frames – for collaboration or protest – are perhaps not as rigid in this case. Rather, it is worth considering that common mental frames such as arguments such as 'we came from the same community' put forward by the urban health committee could be used. It is also worth keeping in mind that the TAC is an organisation that has both an oppositional and a collaborative relationship with the state. This may suggest that different mental frames can be used by the same actors depending and the context.

While these collaborations were only in the beginning stages, they should be understood as a way of exploring how collaborative and adversarial structures could be working together in this local context. Organisations and individuals to some extent straddle the engagement-protest divide or the invited-claimed participation divide. At times these divisions appear clear-cut. At other times people engage in different spaces. The fact that the TAC used to have members in all health committees in the sub-district suggests that they saw health committees as a potential vehicle for influence. This resonates with Thompson and Nleya's (2010) point that people engage in different ways, both through collaboration and protest.

Moreover, it is my contention that the urban health committee indirectly benefitted from the TAC's and the SACP's adversarial countervailing power outside the invited space. An illustrative example of this was health committee members' perception that the provincial health minister worked with them because she preferred working with health committees rather than adversarial structures. The fact that the health services engaged more proactively with the health committee around the SACP protest is another example. It resulted in stakeholders getting together to organise an engagement with the wider community through a health imbizo, a development which conferred some legitimacy on the health committee. The very existence of alternative adversarial structures outside the participatory space may provide a form of countervailing power inside the space in making the health services more

receptive to invited participation. In the end, then, invited participation was both challenged and strengthened by a claimed space.

However, there were also other sources of countervailing power available to the urban health committee. In the process of responding to the SACP march, the power of the Upper Structure became apparent. This resonates with Erasmus and Gilson's (2008:363) assertion that links to networks and powerful actors can be a source of power. The Upper Structure's power derived to some extent from collective power, as it represented health committees in the entire sub-district, but also from powerful and resourceful individuals, notably its chairperson, whose organisational and strategic skills the health committee benefitted from. My assertion is, then, that there are alternative paths to collaborative countervailing power than those suggested by Fung and Wright (2003c).

In the rural committee countervailing power was clearly absent as the committee by its own admission consisted of 'five individuals' and 'met for nothing'. The absence of countervailing power resulted from stakeholder and community disengagement. It is difficult to see where countervailing power could be generated. There is no structure similar to the urban Upper Structure or strong organisational link that could provide or generate countervailing power. Neither are there obvious organisations, besides perhaps the farmworkers' organisation. Perhaps, therefore, health committee members considered engaging in more disruptive and protest modes of engagement. These calls could be considered a result of the health committee not having sufficient collaborative countervailing power and therefore considering shifting its attention to a form of participation where it has witnessed countervailing power, namely in the form of mobilisation and protests.

6.7 Conclusion

Health committees opposed the legislation's model of ministerial appointment of health committees based on an argument that it was incongruent with their understanding of health committees as structures composed of community representatives. They conceptualised themselves as being community representatives. However, their claim to representivity was challenged in several ways. The processes leading to the formation of health committees, in both committees led by community leaders, raise questions around their claim to

representivity as it resulted in representation with limited attention to inclusive and diverse representation. Representation was also limited to organised structures. In the urban site many community members indicated that they were not invited or aware of the process of forming the health committee. In the urban area, the health committee's claim to legitimacy was also challenged by charges that the committee was unknown, dysfunctional, not accountable to communities and ineffective. Both committees acknowledged their difficulties with visibility and accountability. In addition to these challenges to their substantial legitimacy, their instrumental legitimacy was contested through an indirect claim that participation was more effective.

The chapter has argued that health committees are left with limited collaborative countervailing power because of their difficulties with claiming legitimacy. It argued that collaboration between local adversarial community structures and collaborative participatory structures could potentially strengthen health committees' countervailing power. Finally, I have argued that irrespective of whether such collaboration takes place or not, invited participation is strengthened by the very existence of adversarial structures outside the space as it promotes the health services' receptiveness to invited participation. The urban committee also drew on organisational links, primarily to the Upper Structure. The rural health committee, in contrast, lacked such links.

Having described how current participation takes place in a context of limited countervailing power, the next chapter looks at how this affects health committee participation. The chapter examines how constraining forms of power impact on participation, but also outline how enabling forms of power result in agency.

7 Constraining and enabling forms of power in practice

7.1 Introduction: A turning point

The urban health committee has decided to go to the facility manager. They have a number of issues they need to discuss with him. They want to set dates for health committee meetings, which tend to occur in an ad hoc fashion, something they have come to believe impacts negatively on their participation as they are not prepared for the issues that may be raised for discussion. This is exacerbated by the fact that no agenda is prepared in advance, leading to issues not being followed up. The committee also wants to discuss how they carry out one of their main functions: their involvement in the complaint process, where they seek more influence. Finally, they raise the issue of their access to information as they believe that insufficient access to information impacts negatively on their role. In short: the meeting is about how the health committee can improve its functioning and enhance its influence.

The meeting between the urban health committee and the facility manager represents a turning point, a point where critical issues are raised and where change begins to happen. It reveals how both constraining forms of power and enabling forms of power impact on participation. The incident highlights important forms of hidden power, namely management of information and collaboration with the facility manager. At the same time, the incident also reflects important enabling forms of power such as collective action.

In this chapter, I focus on how participation was practised and how different forms of power impacted on participation. Drawing on the conceptual understandings of participation presented in Chapter 2, the first part of this chapter will consider health committees' ability to express community needs, influence and hold the health services to account. In other words: how they practise participation and how effective they are in their participation. The second half of the chapter explores how various forms of constraining power impact on participation. This is followed by a section that explores both actual and potential sources of enabling power.

7.2 The champions of the complaints system? An example of limited participation

In this section I will use complaint management in the urban health committee as an example of how participation was practised. For the urban health committee, a core function was opening complaint boxes. Through patients' complaints, facility management and the health services receive feedback about the services they render, feedback that ideally should be used to improve service delivery. Complaints and compliments hence present an important link between the users and the health services and can be viewed as an important accountability mechanism. As in other clinics, complaint and compliment boxes are placed in the clinic. Above them are posters explaining how patients can complain about services, make suggestions to improve services, or compliment the clinic or staff. The posters also explain how a complaint can be escalated to higher levels in the health services if a complainant is not satisfied with the outcome.

It is the urban facility manager who has decided to involve the health committee in complaints. He explained that, according the Department's policy, the facility is encouraged to find a neutral person to accompany a representative from the facility when opening complaint boxes. He prefers involving the health committee, because it ensures transparency and accountability, and he is convinced that the health committee's engagement in the complaints process contributes to improved service delivery and patient-satisfaction:

> They [the health committee members] are not only there to open boxes. People become aware of complaint procedures. It [their involvement] also ensures that people will not be victimised. … Complaints are a way of strengthening service delivery. It gives us feedback on what is concerning people and what the end-users expect. (Urban facility manager)

Approximately every two weeks, members of the health committee meet with a facility representative to collect complaints. During the collection, one of the health committee members inform patients in the waiting areas about the complaint process and about the health committee. After all complaints are collected, the committee or some of the committee members gather in one of the facility's boardrooms. Here they go through all complaints, register which section of the facility they come from and their content. Next, they phone the complainants to get more information about the complaints, before the information is handed over to the facility manager. From that point the health committee's involvement ends and the facility management takes over. A report is supposedly sent to the health sub-district

about the number of complaints, types of complaints and resolutions. According to the facility manager, this is reported back to the health committee, though I never witnessed that taking place.

The urban committee viewed complaint management as one of its most successful roles and explained that many complaints have resulted in improved service delivery. These include reducing waiting hours and improving the quality of care, mostly related to treatment of patients. Initially, the urban health committee was happy with their involvement in the complaint process. However, irrespective of their past successes, the health committee began to ask questions about the quality of their engagement.

> Complaint management normally ends with the health committee phoning complainants for more information – then we give the report to the manager. And normally that is the end of the story. Mostly, we don't get to know what happens. We do not suggest remedies. There is no clear direction on what happens to complaints. (Nonzwakazi)

The following comment indicates that the health committee believed that feedback from the manager was only forthcoming in positive cases: "There are complaints that the facility manager champions and then he gives feedback. He will ask a person to talk in front of the health committee and talk about how a complaint was solved," said Nonzwakazi. Other comments reflected on the health committee wanting to take a more active role in the resolution of complaints: "We do not get any feedback. That needs to end. We must attend to complaints till they get resolved. We are here to champion complaints, to get results," argued Nkosi. In addition, the health committee was concerned about limited transparency in the resolution of complaints, highlighting that the committee and the facility manager viewed this issue differently.

> There is no transparency around complaints. The management just comes back and say we have resolved the problem. But we don't get the details and have no chance to interact with patients, it is only the facility manager that says it [how the problem was resolved]. No one else can confirm it. When some complaints go directly to facility, we don't get a report. We want to open complaint boxes, to be the champions of the complaint system. (Sipho)

Finally, the health committee was concerned that they did not receive any information about trends of complaints.

The health committee also reflected on their role in complaints management as an important form of community accountability - an alternative to bureaucratic accountability. They expressed concerns with the health system's handling of complaints, where complaints end at with the facility manager or the health sub-district with no health committee involvement. "You are just passing the kids to the mother," Nonzwakazi argued, using an isiXhosa proverb to express her view of the current procedures, where health services monitor their own performance.

Another concern emerged when the health committee discovered that complaints were managed differently in different sections of the clinic. In the HIV/TB section, management often opened complaint boxes without involving the health committee. Furthermore, the TAC undertook its own collection of complaints, according to a TAC representative, because they were concerned that complaints were not dealt with adequately. In addition, the committee also discovered that some complaints go directly to the facility manager. This could partly be because instructions on posters in the clinic indicate that patients can address their complaints directly to the facility manager. There was no mention of the health committee being involved in complaints in the complaint instructions. This led the health committee to question why there was no coordinated complaint management system and what their own role in the process was.

The issue of complaint management was one of many that health committee members addressed with the facility manager at the meeting described in the introduction to this chapter. Subsequently, they noted changes in how the facility manager engaged around complaints. For instance, they raised an issue around a staff member who was perceived to treat patients with disrespect. The facility manager instigated internal procedures, and though the health committee was not involved, they were informed about the process and believed they were instrumental in identifying the problem and seeing to it being addressed. The meeting also resulted in an agreement that the committee should be more involved in resolving complaints and should be informed about all complaints, including those that come directly to the facility manager. There was an agreement that all sections of the clinic would

open complaint boxes in the presence of the health committee, resolving the issue with the HIV/TB section, though I did not observe these changes taking place.

The rural health committee was not involved in the formal complaint process and had very little information about the complaints. The committee believed they should be involved in the complaint process. The facility manager, on the other hand, argued that she preferred to address complaints immediately, especially if they related to a staff member. The health committee was concerned about how complaints were addressed. They feared that the complaints were 'thrown in the dust bin', as they expressed it. "My problem is: what procedure is being followed. There is probably no complaint procedure," Laurie stated. They also believed that the clinic would be viewed as more transparent and accountable if the health committee was involved in complaints, and that this could improve the relationship between the clinic and the community. There were discussions on more actively seeking influence in addressing complaints, though this did not happen during the fieldwork period.

Complaint management provides an illustrative example of issues related to how participation was practised and thus foreshadows some of the themes to be addressed later. It shows a limited form of participation, where the urban health committee's involvement ends with opening boxes and having limited influence in resolving issues. The section below looks at how the committees brought community issues to the attention of the health services.

7.3 Missed opportunities: identifying and articulating issues

As the Act had not been implemented when the research took place, health committee participation was practised based on how health committee members and facility managers conceptualised participation. As was evident with the complaints process, facility managers played an important role in determining the role of the health committees.

The urban health committee identified issues through the complaint system and by monitoring health service delivery. In both committees monitoring was unofficial; health committees spent time at the clinic, checked queues, monitored quality of services and assisted patients or facilities. Another avenue for identifying issues was through community members approaching health committee members with issues of concern. Overall, health

committees identified many issues related to health and health services that could potentially be used to strengthen service delivery. Sometimes they articulated these to the health system, sometimes not.

For both committees, an important issue identified was that many people do not access health services. Several reasons were put forward for this. In the urban committee it was argued that people were often uncomfortable with accessing services, because they did not want to be seen at the clinic as they did not want to be identified as being ill. This pertained in particular to HIV and TB because of stigma, but according to health committee members it was a more general problem. They argued that many people were in denial about many illnesses. Denial was more closely associated with HIV, but also to illnesses such as diabetes.

Staff attitude was also frequently identified as a problem leading to people staying away from the clinics. “The way the sister speaks to you, you don’t want to go back to clinic,” said a farmworker from the rural committee. In relation to HIV/TB patients in the urban area, it was argued that staff attitude resulted in patients defaulting. Improving clinic attendance through improving the way services were rendered and addressing how patients were treated was therefore considered an important role for both health committees.

Lack of privacy, in particular in the HIV/TB centre in the urban clinic, was identified as another reason for people not seeking care, which resulted in patients defaulting on treatment. Another issue that impacted on attendance was, according to the health committees, that many people are unaware of the type of services offered at the clinic. Conveying information was therefore also considered important by health committees.

The urban facility manager provided an example of a fruitful collaboration with the health committee related to diarrhoea cases in young children in summer. Many children with diarrhoea come very late for treatment because of a belief that a child vomits because of a bad spirit. Parents take children for treatment to sangomas (traditional healers) or local (African-Zionist and Apostolic) churches. This results in children becoming very dehydrated, and they come to the clinic only as a last resort. The facility asked health promoters to provided training for the health committee, which in turn was expected to convey the information to the community. A significant drop in cases of diarrhoea followed, something the facility manager attributed to the intervention. This indicates that committees can play a

role in mediating between different understandings of health and health practices; and in disseminating information.

In the rural committee, farmworkers' access to health care was an issue frequently discussed. Health committee members argued that farmworkers had difficulties accessing health care because they often live far from the town where the clinic is situated. They either have to walk long distances or spend money on transport. Their access to health services is, according to the committee, made difficult by a doctor not wanting to give farmworkers sick certificates. When returning to their place of work without a sick certificate, they lose a day's wage.

Facility managers also shared issues in meetings and asked for committees' assistance. In the rural committee, this included a request that the committee should promote male circumcision, a prevention strategy to reduce HIV transmissions. The committee was also asked to play a role in getting the community to bring sick children to the clinic earlier, as many children are brought to the clinic late for treatment, resulting in many hospitalisations. In the urban committee, the facility asked the health committee to promote pap smears, while sisters at the maternity unit wanted them to distribute information discouraging women in labour from taking alcohol 'to release the baby' when giving birth, something that the maternity unit reported was common practice. These examples also suggest that health committees can play a role in promoting health seeking behaviour and disseminate information.

In the urban health committee some issues were raised with the facility manager and dealt with successfully, such as creating more privacy in the pharmacy and reducing waiting time. But many issues were never raised in health committee meetings when the manager participated, despite health committee members indicating that they were going to raise them. These included dissatisfaction with the suspension of a popular doctor, disappearing folders, reasons for defaulting, or a concern about homebased carers' providing inadequate services.

Despite the many issues relating to farmworkers' access to health care and besides farmworkers being part of the health committee, the issues relating to farmworkers' access to health care were not raised in health committee meetings attended by the facility manager. Often the committee would resolve to address issues as the following comment suggests:

“We will have to look at it seriously. We will communicate with the facility manager and she needs to answer to it,” argued the chairperson. However, these issues were never raised.

The fact that issues were not always raised meant that there were many ‘missed opportunities’ for influence and the health services missed many chances to get feedback on service delivery.

Health committees also missed many opportunities for follow up on issues they had identified. They would “let things slip”, as Thando commented. This was something the urban health committee was conscious of and attempted to address. An illustrative example was around the issue of name tags and t-shirts, an issue of importance because the health committee believed it would address their problems with visibility and hence enhance their legitimacy. Yet, although the issue was discussed throughout the fieldwork period of two years, there was no resolution by the time fieldwork ended. Another example was their claim that they would ask the facility manager to discuss the Act to get clarity on their role, but they never approached the facility manager. When asked why they did not follow up, they often referred to health committee members’ commitment.

The issue of not acting also resonated with the rural health committee. Many pronouncements were made about the need to establish a health committee with ‘stakeholders’ representing community organisations, but these remained only discussions. Pronouncements on taking up issues related to complaints about services were also made frequently, but not followed through. In a later section I reflect on why health committees did not always raise issues with the manager or follow up.

The section has highlighted that the ability to express and identify issues does not necessarily lead to influence, highlighting the importance of distinguishing between ‘voice’ as an ability to identify issues and the agency to articulate issues and elicit a response.

The previous two sections have illustrated how health committees play a role in accountability and sometimes in raising issues with the health services. It highlights many potential roles: mediating between different health system, disseminating information, bringing system to the clinic and ensuring people are aware of services. At times they were involved in finding solutions. But the sections also highlighted that their influence was

constrained. The sections showed many missed opportunities for raising issues and have influence. The next section uses the frameworks described in Chapter 2 to assess their role, and the degree and level of their participation.

7.4 Role, level and degree of participation

The PHC approach suggests that participation in health systems should be about role (in governance), degree of influence in decision-making on occur at different levels.

In terms of roles, there was no evidence that health committees were involved in strategy, planning and implementation as envisioned in the PHC approach. They played a role in accountability in the case of the urban committee through complaint management and in both committees through informal monitoring and in general through attempts at 'holding the facility to account' for service delivery. They provided community input and they played a role in conveying information to the community but had limited input in finding solutions. Clear evidence of this was the urban facility manager's assertion that: "Generally, the facility finds solutions to problems, but [the] health committee checks and monitors."

Both health committees were largely excluded from dealing with issues such as budget allocation, planning, staff issues and strategy. They did not have any influence on policy level as envisioned in a PHC approach to participation.

In terms of degree of participation, it was also evident that health committees had limited influence and decision-making power. The urban health committee often provided input and was consulted. Decisions were sometimes taken in collaboration, but in other instances influence in decision-making was limited, as illustrated with regards to their role in dealing with complaints. The issue of limited influence was more pronounced in the rural committee and perhaps best summed up by the chairperson who asked: "Where can we have influence? We want influence, but currently we do not have it." In the rural committee, a feeling of not achieving anything prevailed. "Too many people come to us and ask us to do things. We address some issues, but we are going nowhere," said Marike.

With regards to level of involvement, health committees mainly operated at the local facility level. The urban committee engaged with the wider health system both at sub-district level

and provincial level, but the engagement was ad hoc, and not focused on *addressing* health system issues. For example, the urban committee was invited to many meetings, such as the meeting where the provincial Department of Health presented its budget to communities described in the introduction to Chapter 5, but this did not translate into influence on the budget.

On another occasion they participated in a community engagement meeting organised by the sub-district. While community members could raise questions, the meeting was – like the budget meeting – mainly a meeting where health managers conveyed information.

The rural health committee, in contrast, had no engagement or communication with the wider health services, something they found frustrating because they were convinced that participation required them to have access to higher levels as the issues they identified could not be addressed at facility level. The main issues the rural health committee focused on was expanding services and an extension of the local clinic, which they argued was under-capacitated as a result of population growth in the area. In addition, they were concerned about staff shortages. In particular, the fact that the clinic does not have a full-time doctor was raised frequently. The committee argued that without collaboration at a higher level, participation was futile as they could not address the issues they had identified. They acknowledged that the facility manager would listen but could not resolve the issues. Hence, they discussed addressing matters at higher level, though this did not happen.

The health committee had attempted to approach the previous MEC regarding the extension of the clinic, but gave up after not receiving any responses. They did not make attempts to address the issue with the current MEC. No reason was given for this. The rural health committee greatly lamented their lack of connection to the provincial Department of Health and the health sub-district. At an earlier stage, health committee meetings in the rural committee had been attended by a representative from the sub-district, but her attendance stopped without any explanation, leading the health committee to surmise that the sub-district did not take the health committee seriously.

In the rural committee the feeling of having limited influence was strong. It was often expressed as a feeling of 'being stuck'. Marike lamented: "We meet for nothing." The committee was convinced that the facility manager was not keen to involve the health

committee. “(She) never promotes the involvement of us where we are going to take an initiative to engage. Even though she knows there is a structure, she will try to avoid it,” argued Marike. Thus, participation was experienced as a form of partial participation, which left the health committee feeling they had limited influence and were somewhat disempowered.

It is evident that in practice health committees have limited access to other levels of the health system. The legislation envisions collaborative relationships with health facility boards, district health councils or provincial health boards, but there are no organisational arrangements to ensure this. Furthermore, there are no structures with community representative at sub-district level, though the legislation indicates that the MEC may create such structures. Thus, the issue of access to the wider health system is not likely to change with the implementation of the Act.

Overall, the analysis shows that health committees had limited roles in governance, limited decision-making and that their activities occurred only at local level. Hence, their participation does not reflect a PHC approach.

7.5 ‘Moving without us’: partial participation

Though the urban health committee took pride in their role, they also raised concerns about the scope and quality of their participation. For instance, they questioned why they were not involved in the appointment of staff or had any influence on the budget. Although they received information about the budget, they provided no input into how it was devised and spent. The committee agitated for wider involvement and expansion of the participatory space, so as to increase their influence in decision-making, as will be shown in the next section.

The urban health committee framed their limited influence as the facility ‘moving without them’. The complaint management in the urban committee was an example of how the facility sometimes ‘moved without’ the committee. Expressions such as: “In some activities we are involved in others not,” and “we just saw things moving without us” were repeated often. “Sometimes the health committee is being informed about certain issues, and

sometimes it is being side-lined," explained Sipho. Additionally, the health committee complained that they only were asked for help when there were troubles. They were not consulted on other issues or asked for their input. This made them reflect on whether they were taken seriously by the health services.

A second turning point afforded the urban health committee some gains in terms of increased influence. This was a community meeting organised by the health sub-district to provide feedback on health issues in the sub-district and included a presentation on how the sub-district as a whole and specific clinics performed in terms of a number of health indicators. But the meeting also turned into an opportunity where health committee participation was discussed.

At the meeting, senior officials expressed their support for health committee participation. Moreover, they indicated that health committees should know the facility's budget and that they believed they should be part of staff meetings. Sub-district managers obliged facility managers to share budgets with health committees. Another change that occurred after the community meeting was that the urban health committee was subsequently invited to attend staff meetings, apparently after a directive from the sub-district. The health committee found that their first staff meeting improved their relationship with staff. "It has created a space where the facility manager said to staff: don't treat health committees as watchdogs because they represent the community. When the community have issues, they will speak through the health committee," explained Nonzwakazi.

The health committee attended only one staff meeting and was unsure why the practice did not continue. Many months later the facility manager mentioned the staff meetings again and invited the committee, but no one attended. Thus, like many other initiatives, this arrangement became a false start, an improvement that was not sustained. This incident serves as an example of how pressure from a higher level in the health system can function as a leverage point for change, but also as an example of how changes are often not sustained.

7.6 Ad hoc participation

The way health committee participation was organised impacted negatively on participation. In both committees, meetings were supposed to occur monthly, but meetings occurred infrequently and were often cancelled supposedly when the facility manager was unable to attend. Sometimes the committees would meet irrespective of whether the managers were available or not. Neither committee had a meetings schedule and meetings therefore became ad hoc, often held when facility managers were available. Furthermore, there was no agenda for meetings. The urban committee took minutes, but no formal minutes were taken in the rural committee. Both committees were conscious of the impact of their organisational difficulties and the need for improvements.

In the urban committee participation often occurred in an informal manner, where health committee members either individually or in a small group went to the facility manager with issues that had come to their attention. At times the urban facility manager preferred to engage with the health committee in an ad hoc basis, which had advantages, but also weakened the committee because it was associated with lack of follow up. The Upper Structure chairperson emphasised the need for better organisation and suggested that the health committee should have a meeting without the facility manager before meeting with him to prepare and ensure that issues were addressed. The urban committee attempted to change the ad hoc nature of meetings by suggesting to the facility manager that they decide on a meetings schedule. This occurred at the meeting described at the beginning of this chapter. In addition, they suggested that the health committee draw up an agenda. A meetings schedule was never compiled, but towards the end of the research period the secretary began to prepare a written agenda for meetings.

Overall, I argue that the participatory process gives an impression of participation. However, practiced participation is limeted when viewed in light of the conceptual definition of participation as influence in decision-making in health governance. The analysis of health committees' role, degree and level of participation suggests that their influence is somewhat limited. There were many missed opportunities for ensuring community input into the health system as well as challenges in holding the health system accountable. Their participation was also constrained by not having access to higher levels of health system. Practised

participation can be viewed as being a 'veneer of participation' compared to the conceptual understanding of participation.

The limited form of participation can also be viewed with reference to Fung and Wright's (2003c) assertion that participation can be neutralised when participants do not have sufficient countervailing power, as is the case here. This does not mean that a form of participation is not taking place, but rather that the form of participation that takes place depends on actors engaging in participation and on their values and commitment. Participation in this context will to a large degree be contingent on the good will of traditional power-holders.

This section has illustrated how participation without sufficient countervailing power becomes participation with limited influence. The following sections will explore how constraining forms of power contribute to this.

7.7 Constraining forms of power

Drawing on Lukes (1974) and the *Powercube* (2011), this section will consider how visible, hidden and invisible forms of power impacted on practised participation. Hidden power is here considered as power that prevents issues from reaching the decision-making arena, because actors are unsuccessful in their attempt to raise them. Hence, they become non-decisions or non-events (Lukes, 1974). Invisible powers are internalised beliefs, attitudes, lack of confidence etc., which impact on agency and resulting in issues never being raised.

7.7.1 Management of information: the less we know the better?

The management of information emerged as a central form of hidden power. This relates both to the availability of information, control of information, selective information sharing, one-directional information sharing and how information was presented. Limited information was consistently mentioned as a barrier by health committee members. In the urban committee this was, for instance, clear in relation to complaints where it did not always receive feedback and had no information on trends. Hence, they did not have any information on resolutions of problems and could not function as an effective accountability structure.

The perception in both committees was that facility managers do not share necessary information with them. “We don’t get much information, for instance, about the budget. He (the facility manager) reports very limited information. There are gaps that need to be filled,” lamented Neliswa. “There are lots of things we are not aware of. Opening hours, how many doctors the clinic has, what services are rendered. There are lots of gaps in terms of information. Till we get such information it is difficult to help,” argued Yeliswa.

There were repeated claims in the urban committee that the facility manager reported selectively on positive issues. “The manager limits the health committee by giving us [the information] that he wants to give us, gives brief reports and only on the positive. Nothing on lost folders or major diseases,” argued Yeliswa. The facility manager – according to them – would insist that he could not share everything with the health committee. According to Nonzwakazi, the urban facility manager would refer to issues being too sensitive when they asked questions.

Both committees framed management of information as selective reporting by the facility managers, as the following comment from Sibongile illustrates: “They just report on what is suitable for them.” In the rural committee the relevance of the information given to the committee was questioned.

> I feel that the kind of reports she gives, for me, it [the information] is not that important or relevant, while the health committee needs critical information. She is keeping those kinds of reports and reporting on things that do not really matter. (Elise)

The rural health committee was particularly concerned that the facility manager did not give them any information about plans to extend the clinic and expand the services rendered.

Moreover, information was not forthcoming, the urban committee claimed. Instead, they had to ask to get information and feedback. An example of this was the complaint management, which was not a standard item in health committee meetings. “We have to beg to ask for feedback,” lamented Sipho. Health committees argued that without information there was lack of transparency and accountability. Limited transparency was raised numerous times in relation to a staff member who was allegedly suspended. The urban health committee

claimed that the facility manager pointed to the confidentiality clause in the Act to argue that he could not share certain sensitive information with the health committee, despite the fact that the Act had not been implemented yet.

The health committee expressed concerns that the Act affords power to the facility manager with a section that says that health committees can only request information if it does not violate the patients' and staff's right to privacy (*Western Cape Health Facility Boards and Committees Act 2016*, 2016: ss13(1)(d). They believed this prevents the committee from being involved in addressing staff issues. "It is not them [the management] who beat us, it is the law. They have the right to raise the issue of confidentiality," commented Beatrice. On a more general note, the urban committee believed – or feared – that the Act was being used to curtail their access to information. "I think the facility manager has gone through the Act and therefore he just provides a brief report. There are lots of activities that we are not informed about: Diabetes Day, World Aids Day, Women's Day," explained Yeliswa.

Information was in some cases perceived to be one-directional in the sense that health committees would receive information but have limited opportunity to pass on information. For instance, the rural committee conceded that the facility manager provided a report and sometimes asked for the committee's opinion, but they argued that she attended meetings to give information, rather than to listen. Health committees also held back in requesting information, similar to their reluctance to voice issues.

There were contrasting views on whether information was deliberately being withheld by facility managers. In the rural committee there was a strong perception that withholding information was a strategy used to limit their influence. "I think that there is some information that she [the facility manager] is hiding to share with the forum [referring to the health committee]," said Marike. When I asked what information, she replied that she cannot point to it, but is convinced that the manager withholds information. Laurie was certain that the facility manager has information pertaining to the extension of the facility that she did not share with the health committee. He was convinced that the Department also controlled information and, through this, made participation difficult: "Sometimes it is better for the Department, for all sorts of reasons, the less we know the better," he argued.

In the urban committee views were divergent. Some claimed the facility manager withheld information intentionally, others argued that he was waiting for the committee to ask for information. The facility manager apparently indicated that he is willing to share information but had not done so because he was unaware that the committee wanted information. According to Beatrice, his response was that he does not intentionally withhold information but is too busy to brief the committee. He also argued that it is difficult to discuss everything with the health committee, as there are many projects and issues that need to be dealt with speedily.

In relation to giving feedback on complaints, the facility manager reportedly said that he simply reports on those that he remembers, but he may forget others. The facility manager then proposed that the health committee should come to him once a week to receive feedback.

> He proposed that he was not aware that we wanted to be part of what happened in the facility. …. We need to meet weekly. He was quite open and said that he is willing to work with us. He proposed that if we can meet weekly, he will engage with us. Now, we are going to work hand-in-hand with the facility manager. (Beatrice)

However, six months later the weekly meetings had not started. When I asked the facility manager, he argued that he did not withhold information, but referred to the health committee's commitment as an issue that impacted on information sharing.[27]

The community engagement meeting described earlier was a second turning point, which resulted in a change in access to information. "That session, if it wasn't for that session, it has opened up a door and created a space where the facility manager shares information with the health committee," commented Yeliswa.

Ease of understanding of information was another issue that impacted on participation. An example of this was the community engagement meeting where the health services presented key indicators on the clinic and the health sub-district's performance. While the clinic overall

[27] I re-interviewed the urban facility manager towards the end of the research period to get his view on the committees' claims. Attempts to set up a follow-up interview with the rural facility manager were unsuccessful.

is performing well, there were also areas of concern. A particular issue that was highlighted was the low number of pap smears conducted. Information on the clinic's performance could have been used to hold the clinic accountable and discuss how to improve services in areas where the facility did not do well. Yet the information was never used. When I enquired about this, months later, only one health committee member indicated that the information was useful and could be used to discuss the facility's performance.

Beatrice reflected on how the information and statistics could enable the committee to discuss the clinic's performance. "Since it is the first time we are getting these details we [the health committee] have not had time to discuss how to go about it," argued Beatrice. She indicated that the health committee would do so in the future, but the issues were never raised. The rest of the committee had not considered how to use the information. This could reflect difficulties in decoding the technical language used in the presentation, and if so points to a form of invisible power, which is likely to be linked to their educational background. Health committee members do not have medical training and also have limited formal education. This may impact on how accessible the medical language is.

Participants' difficulties with understanding health information presented by health officials could be viewed as a form of hidden power in that presenting information in a way which is not easy to understand, such as the statistics on health indicators, can disempower participants. Like access to information, the effect of this was ineffective participation.

Facility managers' discretion to decide what information to share in practice can be viewed in light of Fung and Wright's argument that power enables officials to engage in participation, but at the same time protect their prerogative (2003c:264). Without making a judgement about whether the way information was managed was deliberate or not, it is evident that it could function as control. It could enable health officials to participate without surrendering too much control, resulting in a 'partial' form of participation. The issue of access to information is unlikely to be resolved with the implementation of the Western Cape, which does not guarantee committees access to information, but only allows health committees to request information.

To conclude, the way information was managed was a form of hidden power that impacted negatively on participation as it prevented the health committees from raising and dealing

with issues. Conversely, it is easy to surmise that improving information access and ensuring that information is presented in a way that is easy for lay-people to understand could enable better participation.

7.7.2 Availability of and collaboration with facility managers

Collaboration between health committees and facility managers is crucial in invited participation. In particular facility managers' availability to attend meetings is paramount.

Facility managers' attendance in health committee meetings was an issue in both committees though more so in the rural committee. In the last six months of fieldwork she did not attend any meetings, though it was difficult to ascertain whether she had been informed about meetings. Facility managers often referred to their busy schedule as a reason for not attending, postponing or cancelling meetings. This severely influenced the health committees' functioning.

The rural committee interpreted the manager's lack of availability as a form of control or power, a tactic. There was a perception that she deliberately excused herself as the following comment indicates: "[The facility manager] is like 'I can't meet you, no time, too much stats to do'," the chairperson mimicked as many members laughed in agreement. In fact, there was a belief amongst members that she was not in favour of community participation and health committees, because "she knows she is going to get into a lot of trouble," as the chair put it. Hence, they believed she had employed a tactic of setting up meetings that she would later cancel. She "fears that the health committee will cause problems. Fears losing control. That we will hold her accountable," said Laurie. They also argued that when they raised issues, she withdrew. "She doesn't take the committee very seriously," lamented Elise. The chairperson explained that the facility manager did not listen to the committees' concerns. "She thinks it is about coming here to report. She comes to talk, not to listen," said Laurie. During the research period they began to describe her as 'a stumbling block', an expression that they used repeatedly.

The urban facility manager attended health committee meetings regularly, though there was some inconsistency. Sometimes his deputy or another staff member replaced him. In the

urban committee members were more likely to accept that the facility manager was not always available. However, at times committee members charged that the facility manager used his presence as a way of controlling the committee or that he did not prioritise participation. “We accept that he is very busy, but community participation is also important,” argued Yeliswa. The health committee became increasingly concerned that meetings were postponed or cancelled. Concerns were raised when a meeting was postponed after the meeting with the facility manager to discuss setting dates for future meetings. “He does things to gain a reputation to be a facility manager that works with the health committee. But we don’t get much information on what is going on,” said Neliswa. There was a perception amongst health committee members that the facility manager felt threatened by health committee participation, because the committee asked for details about what was happening in the facility. Some members reflected on the facility managers’ attitude stemming from how the Department views health committees: “If the Department really respected health committees, then the facility manager would also do it. He is following the trend,” argued Sibongile.

In both committees there were arguments that for participation to be effective, the health committee should meet with the entire management team. Health committee meetings in the urban committee had previously been attended by unit managers. “Previously all heads of departments [units in the facility] were present and would report. Since [then] we have been told that they are busy and [the facility manager] reports on their behalf,” explained Nonzwakazi. The change took place after the health committee participated in the Learning Network’s training. According to the committee, they noticed that after the training the section managers stopped attending health committee meetings and they surmised that it was because health committee members now wanted to hold them accountable. “The training made us ‘sharp’, but it challenged management,” argued Nkosi. Nonzwakazi added: “It is how they saw the health committee questioning them on service delivery that made them reserve themselves.” Thus, while health committees were empowered through a capacitation programme, it is important to note that this also led to tensions that indirectly had a negative effect on participation.

Facility managers’ availability and collaboration is linked to how they viewed participation and health committees. The facility manager in the rural committee was in principle in favour

of health committees, but she found the value of the current committee limited because of the limited stakeholder representation, as described in Chapter 5.

In contrast, the urban facility manager appreciated the health committee and expressed satisfaction with their collaboration. He saw many advantages in having a health committee, their involvement in addressing complaints being an example. “Health committee meetings work really well in that you get to discuss important issues, for instance complaints of patients and find solutions. It focuses us [management] to meet with them,” said the facility manager. The manager perceived the committee to be ‘the voice of the community’ and argued that having a health committee helped create harmony between the facility and the community.

> We tend to have the facility and the community as two separate entities. Now both are on the same side. [There is] often much debate that the facility doesn’t meet community needs. It helps having the committee as that link [with the community]. You get a feel of what the community want. It is no longer us and them, which can be a risk. (Urban facility manager)

The facility manager talked about community participation as a key responsibility of his. This should be viewed in contrast with health committees’ perception that this was not always his priority.

In the beginning of the fieldwork period the urban committee praised their relationship with the facility manager. The relationship was described as one of collaboration and ‘working hand-in-hand.’ The facility manager was said to have created a space that allowed health committee members to speak their mind. They indicated that they found it easy to raise issues with him. But the urban health committee’s perception of their relationship with the facility manager changed during the research period.

According to some members, the change occurred when the manager excused himself, saying he was too busy. The health committee perceived this to be a form of control: “It is only now that we thought we had a good relationship with the facility manager. Now we feel he uses us. If we were aware, we would have reported it to the Upper Structure,” said Neliswa. Sipho believed that the facility manager’s reaction to their request to prepare an agenda in advance and schedule meetings showed that he felt threated. “Because he will now have to go into

detail about what is happening in our facility," said Sipho. Xholisa commented that the facility manager controls the committee that he 'allows them to dance to his own tune'.

Others began to reflect on their potential role in the change and warned not just to blame the facility manager. "He has said be at the facility. And also with complaints. The committee must be careful shifting blame to the facility, when the problem is their commitment," argued Nkosi. These members argued that the facility manager was committed to community participation but was waiting for the health committee to take initiative. "He proposed that he was not aware that we wanted to be part of what happened in the facility. He said he was not aware. He said we need to meet weekly, so we can … He was quite open. He said he is willing to work with us," said Beatrice and continued:

> Before, the facility manager was very transparent. Is it us or is it something he is hiding? What happened to make the [him] to not be transparent? Is it something amongst the health committee? Does he see us as people who don't really know what we are doing? We need to ask: what is the cause? Ask in a professional manner. Sometimes we are the causes. What happened? What is the cause?

Whether the changed perception of the relationship was a result of actual changes or increased assertiveness on part of the health committee is difficult to ascertain. Towards the end of the research period, the relationship with the facility manager improved again as he and the committee collaborated around the nomination of health committee members and they worked together to plan a health imbizo.

In considering the facility managers' approach to participation, one should also take into account that the policy context is confusing with different conceptualisation of roles in, for instance, the *Ideal Clinic Manual* and the Western Cape Act, two policies that they would be requested to implement.

Facility managers' approach to collaboration and their availability to attend meetings can be viewed as wielding hidden forms of power that impact on health committee participation, irrespective of whether carried out intentionally or not. It can enable managers to engage in a form of limited participation, while at the same time control participation. However, it could also reflect limited health service capacity and resources to participate. None of the managers

in this study had received any training in participation or how to engage with communities. Neither were there financial resources set aside to assist.

7.7.3 'We need to step up': commitment and collective action

Numerous times both health committees raised the issue of members' commitment. They argued that lack of commitment was the main explanation for the lack of follow-up described earlier. They attributed the limited commitment to members' infrequent and inconsistent attendance at meetings and people coming late. The urban committee discussed the issue on several occasions and attempted to address it.

Commitment was also related to a fluid notion of health committee membership, with some members constituting the core of the health committees, whilst others participated more infrequently. This seemed to be accepted practice in the committees. During the course of the fieldwork four members of the urban committee left the committee, whilst some would be absent for a while and return later. The rural committee had a very fluid understanding of membership, with some community members showing up for one or two meetings, never to come back. Both committees met during the day, during working hours. In the rural committee this was an issue for people who were employed. In the urban committee most members were unemployed at the beginning of the research process. During the research period six gained temporary part-time employment through their health committee membership, while one gained full-time employment, which made it impossible for him to remain active in the health committee. Those employed part-time remained active. Health committee membership was associated with access to job opportunities and other personal benefits such as expectations of a stipend and access to training.

Furthermore, members in the urban committee indicated that problems with the chairperson's availability and leadership resulted in poor commitment.

> One of the things that makes us look as not active is that we are being led by a chairperson who is not active. It is commitment that is lacking from the person, who is supposed to be the face of the health committee – it would be great for the chairperson to lead her committee. (Yeliswa)

The rural committee had similar issues and there were many calls for improving meeting frequency, attendance and follow-up. 'We need to step up,' was a sentence often repeated in the rural health committee. In the rural committee poor attendance was sometimes explained to be related to the facility manager's limited availability. However, lack of 'commitment' could also be viewed as a result of many other factors, such as not seeing the benefit of their participation or as not being worth their effort, though the 'committed' member tended to frame this as 'commitment' issues.

The urban committee also faced difficulties acting as a collective. To some extent it seemed to be accepted practice that individual members or smaller groups addressed issues with the facility manager outside health committee meetings. However, at the same time this was seen as causing internal tensions and conflicts as it challenged the notion of collective action. A member suggested that lack of collectivity weakened the committee.

> It starts with commitment from us. Whatever needs to be discussed should not be with an individual, it must be a collective. At times, the facility manager takes the gap because there are some people that would take what is said [in health committee meetings] to the facility manager. (Nkosi)

Beatrice shared the same sentiments.

> When we go individually … he [the facility manager] takes advantages of that. He will then not be transparent to us. But if he sees the unity, he will be transparent. We must work as a team, so we can be transparent as a team. Not go to him individually. He takes advantage of that. (Beatrice)

Others responded with an 'amen', indicating the salience of her assertion.

Members also discussed how they should meet as the health committee to discuss issues before meeting with the facility manager to ensure unity amongst committee members. "We need to go with one voice. We can't go to meetings as individuals and come up with an agenda at the meeting," argued Sipho.

Pateman (1970) warns that participation can become pseudo-participation if participants do not have sufficient power to influence decisions, with the result that they may become disillusioned with the process. It is worth considering whether the challenges health committees faced in wielding influence impacted on their commitment.

Lack of commitment and lack of collective action were constraining forms of power. But the presence of commitment and collective action could also be a potential enabling source of 'power with'. There were examples of incidences where collective action and commitment resulted in agency and change, such as the meeting described in the introduction to this chapter. At the same time, it is clear that in particular the urban committee were aware of the importance of both commitment and collective action.

7.7.4 Lack of confidence, skills knowledge and support

It wasn't just commitment that impacted on health committees' problems with following up on issues. Confidence was often raised as another reason for why the urban health committee did not always raise issues, follow up on issues and sometimes did not request information. The following quote illustrates this:

> As much as we are raising this issue about him [the facility manager] limiting the information we have, when we sit with him, we do not have the confidence to raise it. We are not bold enough. Even though we have a good relationship with the facility manager. (Nonzwakazi)

Moreover, members who were confident in speaking amongst themselves were sometimes not confident to speak when the facility manager was present. Additionally, they explained that they often lacked confidence in bigger meetings. This was, for instance, evident when the stakeholders discussed the SACP meeting. Health committee members were silent, leaving it to the Upper Structure to engage. Their confidence and ability to voice (articulate) could also be seen in relation to their weak engagement in relation to the Act, where they conceded that they did not express their views sufficiently.

Lack of confidence could be viewed as a form of invisible power, because it is internalised. As the *Powercube* suggests, invisible power can be seen in members lacking the confidence

to speak, lacking knowledge and having certain beliefs that constrain them. Not raising issues has an impact on participation, as it ultimately means that these issues remain outside the participatory sphere, where decisions are made. Previous experiences such as their experience with not being able to assert influence during the consultation process may also have an impact on their confidence. Conversely, confidence can be viewed as an enabling form of power that leads to agency, a form of 'power within'.

An illustrative example of confidence as an enabling power is the turning point described in the introduction to this chapter, where the urban health committee went to the facility manager to change the conditions for their participation. The confidence to do so was a result of a workshop organised by the Upper Structure. According to the health committee, training helped them gain confidence in particular with regards to raising matters with the facility manager.

> We are more confident in raising issues with the facility manager. The facility manager decided not to give information to the health committee around staff, patient numbers, contractors. [He said] he thought it was information we did not want. He is now happy to raise the issues and happy to share the information. The training gave us the oomph [to raise issues]. (Nkosi).

One health committee member believed that the facility manager changed as the health committee became more capacitated with the training. "He was not showing interest in telling [providing information] because the health committee was not clear about its role too. After the training session, he realised the health committee is being equipped. How they [the committee members] raise questions are changing," explained Beatrice.[28]

Invisible forms of power also include limited skills and knowledge. Health committee members' capacity to participate and organise is an important precondition for effective participation, as has been evident in the way they used information and in the way their organisational issues impacted on their participation. Conversely, skills and knowledge can

[28] It is worth remembering that training can also have unintended consequences as was the case when unit managers withdrew from health committee meetings after the Learning Network training. There is a need to be cognizant of such unintended consequences.

be enabling. Research has shown that capacitating health committees through training can improve participation partly through cultivating skills, but also through improving participants' confidence (Haricharan, 2015b, Chikonde, 2017). This was also seen when training improved the urban committee's confidence in raising issues and approaching the facility manager.

Both committees were challenged by not having resources. For instance, this made it difficult for them to run projects, something that became evident in the urban committee when it became involved in a substance-abuse project, initiated by a doctor at the clinic. When there were no funds run to the project, it folded. Health committee members' transport costs to participate in health committee meetings was also an issue. Likewise, it may be difficult to hold feedback meetings without financial resources, which then acts as a barrier or a hidden form of power.

Lack of skills, capacity, confidence and financial resources should also be viewed in the light of participants' educational and socio-economic background and past experiences. The legacy of South Africa's apartheid history has been to marginalise people of colour both politically, socio-economically and educationally. As described in chapter 4, health committee members' socio-economic and educational background suggest that they can be considered to in the main be socio-economically marginalised. Their limited skills and capacity sometimes impacted on their ability to participate. Health committee members' often experienced disempowerment. Examples of this disempowerment was expressed in relation to their experience with training, their limited ability to engage in the consultation process related to the Act and their limited ability to follow through on actions decided upon. Hence, their marginalisation made it difficult to capitalise on openings claimed. Instead, these openings often turned into 'false starts'. This in turn may add to their disempowering experience. It is in this light that the importance of creating enabling, supportive and empowering conditions should be viewed.

I posit that not facilitating participation and creating conditions that enable participation – including capacity building and financial support – should be viewed as exercising a form of hidden power, which impacts negatively on health committees' functioning. Again, Fung and Wright's point, they officials can "protect their prerogative while pretending to participate/collaborate" (Fung & Wright, 2003c:264) ring true. On a more general note,

constraining forms of powers may result in the health services being able to claim support for participation, while at the same time controlling participation and the influence health committees have.

7.8 Enabling forms of power

Having outlined a number of ways in which power constrained participation, and sources that function both as both constraining and enabling, I now explore the main forms of enabling power: belief in a rights discourse, critical consciousness, reflective practice, and power via organisational links.

7.8.1 Conceptualising participation within a rights framework

Beliefs are often considered a form of constraining invisible power, but beliefs can also be a source of enabling power. For the health committees in this study their belief in rights was a source of power to which they referred many times. Having rights and knowing her rights was what enabled Elise to raise her voice, when she felt something was not right at the rural clinic. "Knowing your rights, you have a right to do that," she said. As mentioned, Laurie spoke about rights in relation to holding health services accountable, and Sibongile viewed health committees as custodians of rights. Both committees had strong beliefs in their rights to have expectations of health care delivery and in their right to participate in and hold the health services accountable. This was reflected in their understanding of health committees as governance structures and in conceptualising accountability as an important role.

Gaventa argues that 'how individuals think about their place in the world' (2006:29) can be considered a form of invisible power. This research shows that how people think about their place can also be an enabling form of power. In taking on their role as health committee members in invited spaces, participants clearly envisioned themselves as democratic citizens with a right to have a say in how public institutions are run. Health committees' understanding of their role and their perception of themselves as claims-making agents with rights can be considered as a form of power that resonates with VeneKlasen's notion of 'power within'. Cornwall and Coelho's (2007) argument that people's ability to recognise

themselves as citizens also bears out the importance of beliefs and how people view themselves and their place in the world as preconditions for participation.

Moreover, the previous sections have illuminated that health committee members possessed a critical awareness about how information and collaboration with facility managers impacted on their participation. They were also conscious of how issues such as commitment and collective action impacted on their participation. While they initially accepted their limited role, something that could be considered a consequence of an invisible form of power, they developed a critical awareness of these roles, which enabled them to take steps towards change as when they addressed issues with the facility manager. A belief that they represented communities was also a source of power in the urban committee irrespective of the fact that this notion was challenged. In the rural committee there was a similar belief that they were speaking on behalf of the community, even though their mandate was weaker. Critical consciousness about participation, their own role and the impact of power emerged as a form of enabling power.

7.8.2 Reflective practice

The two health committees engaged in many focus group discussions on issues such as their role, the committees' functionality and the Act. As time passed, they came to see these discussions as a reflective space that allowed them to consider issues related to their participation. During a discussion the urban committee reflected on how the research had assisted them in reflecting on their role and how they practised participation. They argued that such reflective spaces could complement more traditional training and capacity building and enable agency.

> Normally, we just meet. We never had an opportunity to reflect, to structure plans. Reflections play a vital role. It [the research] gives us time to reflect. Also, with issues of complaints. We started thinking how come we only read complaints, but we don't see what happens [to the complaints]. Focus groups helped identify the problem. (Nkosi).

Yeliswa argued that even though the committee had received training before, this training was insufficient: "We get training, but it is not enough. [It is] important to reflect and that is

where your project is useful. It is a good contribution. It helps us to reflect on how to apply things." The others agreed that focus groups created a reflective space that helped them to identify issues that they wanted to change.

Another example of how the research space became a space for reflection related to the Act, as illustrated in the following comment:

> The opportunity we have created in the focus group where we looked at the Act… Yes, it was presented [previously], but we did not have space to discuss it. We had that with the focus group. It has equipped us to such a level that [we] engaged with the facility manager about the Act. (Nonzwakazi)

Participants' continued use of the word 'reflection' suggests that the research became a reflective space for them. This shared reflective space became a space where understandings were forged, meanings made, ideas discussed, and solutions suggested. While this presents a potential methodological problem common in qualitative research, in the sense that the object of study is impacted through the study process, it also suggests that reflections resulting from the qualitative research process can act as a potential source of enabling power. Consequently, research can facilitate reflective practice and the development of critical consciousness that can act as a leverage for change.

Theories on power such as Haugaard's suggest that agency becomes a possibility when tacit knowledge become discursive. I suggest that reflective practice in spaces such as a research settings or training that include reflective practice can facilitate this. Reflective spaces should be viewed as creating a form of enabling power that facilitates the emergence of discursive knowledge.

7.8.3 Power through links to the Upper Structure

An important source of power in the urban committee was strong links to other structures in the community, most prominently their link to the Upper Structure. The Upper Structure was a resource, called upon when there were issues the committee found difficult to deal with, such as the SACP march. The chairperson of the Upper Structure also attended health

committee meetings from time to time and gave advice and directions to the committee. The Upper Structure chairperson displayed more direct power in relation to the health facility and health services and intervened in certain situations, either on his own accord or when the committee or the facility contacted him. His influence and the power it conferred to the health committee should not be underestimated. It was clear that the facility manager and health service managers respected him and listened when he spoke. The health committee gained power derived from links to networks and powerful actors, a source of power also mentioned by Erasmus and Gilson (2008).

The urban committee also had strong links to the facility. The committee was regarded favourably by the facility manager and other managers in the health services, who viewed it as a body that represented the community. In addition, it had links to the health sub-district and the provincial Department of health. The importance of these links was observed throughout the fieldwork period. For instance, some of the important turning points – such as the urban health committee's attempt to expand their participation after the community meeting – occurred because of these links. Changes such as giving the health committee access to the budget and inviting the committee to attend staff meetings were instigated by managers in the sub-district. Similarly, the committee approached the facility manager after training, facilitated by the Upper Structure. Furthermore, the committee was part of a tiered structure for community participation and had links to SANCO, CMHF and the Learning Network (LN). These links resulted in them often being invited to meetings, training and workshops, and gave them access to knowledge, experiences and to some extent resources.

Links to other structures and organisations were largely absent in the rural committee. The rural committee was by its own admission 'quite isolated' and did not have the opportunity to engage with similar structures and exchange experiences. The poor organisational links resulted in poor stakeholder representation in the committee. Its relationships with the facility, the health sub-structure and the provincial Health Department were weak. Consequently, the meetings, training sessions and engagements, which were frequently available to the urban committee, were not accessible to the rural committee.

The difference between the urban and rural committees' access to enabling power resulted in the urban committee feeling more empowered to exert its agency. The rural committee felt more powerless, resulting in more apathy, reflected in expressions such as 'we are stuck' and

'we meet for nothing'. Table 6, below, summarises the forms of power observed in practised participation.

Constraining	**Enabling**
Management of information	
Facility managers' collaboration and availability	
Lack of skills, knowledge and capacity (linked to socio-economic marginalisation)	Skills, capacity (often gained through training)
Lack of resources	
Lack of collective action	Presence of collective action
Lack of commitment (possibly linked to limited influence)	
Lack of confidence	Presence of confidence
	Reflective practice (through which tacit knowledge is turned to discursive knowledge)
	Critical consciousness
	Organisational links (linked to knowledge, skills, collective action and resources)
	Conceptualising participation as a right (beliefs)

Table 6: Constraining and enabling forms of power in practised participation

7.9 Conclusion: power in participation

In this chapter I have argued that participation can be characterised by being limited in terms of role, level and degree of influence. Instead of influence in decision-making in health governance, a form of limited partial participation is practised with some influence, but many missed opportunities for influence. I have argued that there are many constraining types of visible, hidden and to some extent invisible forms of power that contribute to this, including

management of information, collaboration with facility manager, lack of support, financial constraints, health committee members' lack of confidence, limited skills and capacity, challenges with regards to collective action and commitment. I have also argued that there are many sources of enabling power. There were some instances that reflected how confidence and collective action were sources of enabling power. Participants viewed themselves as citizens drawing on a rights-based understanding. They perceived themselves to be claims-making agents. Critical consciousness and reflective practice facilitated reflections on their role and on how constraining and enabling power impacting impacted on participation. It transformed tacit knowledge to discursive knowledge. Finally, links to strong organisations, primarily the Upper Structure, conferred power the urban committee.

Furthermore, I have suggested that constraining forms of power enable powerholders to control participation. They can engage in participation while, at the same time, through direct and indirect forms of power, control participation and hence practise a form of limited and partial participation. This resonate with Pateman's (1970) warning that participation can become pseudo-participation, or Fung and Wright's (2003c) argument that participation without power may become just window-dressing.

While examples of invisible powers were present in the form of lack of confidence, beliefs were not the dominant invisible form of power. It is important to bear in mind that this could reflect a methodological challenge, as it is inherently more difficult to identify internalised beliefs - though prolonged engagement and persistent observations were employed to attempt mitigating this challenge. Furthermore, there were many instances that showed that health committee members did not internalise beliefs, but rather resisted dominant framings or – to use Haugaard's term – did not confirm-structurate powerholders' views.

In the next chapter I return to the Act and explore how health committees made decisions related to the implementation of the Act. I do so in the context described in this and the two previous chapters, a context where they experience the current participation with ambivalence because of their limited influence. At the same time, they experience the invited space being created with the Act as ambiguous.

8 'Doing wonders or being on one broken leg': shifting experiences with and perceptions of spaces for participation

8.1 Introduction: 'let no voice be left behind'

Over a year has passed since the MEC discussed the health committee legislation with health committees at the presentation of the provincial health budget, described in Chapter 5. Implementation of the Act has now begun with the MEC calling for nominations of health committee members. The minister and health officials have organised a health imbizo with communities at the provincial hospital in the town Worcester, about 1 hour's drive from Cape Town. On the agenda for the meeting are presentations of health priorities, a new strategy to combat HIV/AIDS in addition to the implementation of the Western Cape Health Facility Boards and Committees Act.

Despite discussing the implementation of the Act, the invitation has not been extended to health committees. The Upper Structure noticed an advertisement and contacted the Department to secure an invitation. Many health committee members from other parts of the province also attend the meeting, despite not being formally invited. Thus, health committees assert themselves in a space they were not invited to. Members of the rural committee were absent, while two members of the urban committee took part in the meeting.

The implementation of the Act takes centre stage at the meeting. Unhappiness with the Act and the implementation process amongst health committee members is evident and stronger than it was at the budget meeting, where the minister first presented the Act to health committees. A participant at the meeting questions how comments raised during the consultation process (described in Chapter 5) influenced the promulgation of the Act. Another refers to the title of the meeting - 'Patients voice through community statutory bodies: let no voice be left behind'. She argues that in fact voices are left behind. Furthermore, she talks about being 'shut out', 'unseen' and 'not acknowledged', reflecting that communities do not feel listened to.

The meeting thus highlights continued tensions around the Act and the type of invited participation that is envisioned. This tension relates both to the content of the Act, but also to the Department's engagement with health committees in the implementation process.

This chapter explores how health committees responded to the pending implementation of the Act and made decisions about whether to engage in invited appointed participation or explore alternatives, including creating new spaces for participation. It thus concentrates on the later part of the fieldwork period but draws on the previous chapters. The chapter begins with describing the health services' rhetoric about participation and health committees' reaction to this rhetoric, followed by a depiction of their relationship with the Department and the health services. Two narratives of health committees are used to crystallise health committees' experience of participation. Drawing on these narratives, the chapter explores how they made decisions with regards to the implementation process and chose between invited and claimed participation.

8.2 The rhetoric of participation

The meeting in Worcester can be viewed as an example of the prevailing discrepancy between the Department's public rhetoric on community participation and the way participation is conceptualised in the Act and practised.

The meeting presented a public discourse that emphasised the Department's support for and belief in community participation as an avenue to improve service delivery. It also outlined a vision of a comprehensive participatory system where voices of ordinary citizens are said to be channelled through the system to reach the Department and the minister. The title of the meeting encapsulated this public rhetoric: "Patients voice through community statutory bodies: let no voice be left behind." A health official talked about the legislation, outlining a well-known vision of listening to community voices and about health committees having a mandate from the community, enabling them to voice community needs. He also presented a vision of different structures such as health committees, health facility boards, district health councils and a Provincial Health Council, suggesting that like concentric circles, these structures fit together and ultimately lead to 'the voice of auntie Sarah going right through to the minister,' as he put it. Moreover, he talked about the health services wanting people to be actively involved in taking decisions.

The vision for community participation expressed above was also presented during a presentation of health priorities. The Department of Health reiterated its commitment to meaningful community participation, and further argued that the involvement of community governance structures in the budget and planning processes was viewed as essential. The Department talked about health committees being involved in high-level issues such as budgets, health priorities and programmes. When the provincial minister spoke at the end of the meeting, she spoke about information as a right. Finally, she put forward an argument against a stipend for health committees by arguing that if health committees were paid, they would become puppets of the Department and be unable to hold the department accountable. The minister hence emphasised the importance of independence for fulfilling an accountability role yet did not comment on health committees' view that appointed participation provided for in the Act challenge their independence or that the Act does not envision these structures to have an accountability role.

The vision presented was thus one of substantive participation, where participation was conceptualised as being about involvement in decision-making in areas such as budgeting and planning. Ideas of a tiered system that would result in community voices being brought to the higher levels of the health system were expressed. Additionally, health committee members were viewed as representing communities. Their independence was viewed as important in relation to being able to hold the Department accountable. This substantive notion resonates with the conceptual understanding of participation, outlined in Chapter 2.

Contrast this with the Act, which – as argued in Chapter 5 – allows for very limited decision-making and no roles in the budget, health programmes, planning or accountability. Consider how the talk of different participatory structures functioning as concentric circles relates to the Act, which talks about facility managers fostering collaborative working relationship with facility boards and the district health councils but provides no articulation of how these structures relate to each other. The MEC's talk about information as a right also seems in contrast with the Act's wording: the Act says that health committees may *request* information, but without an obligation on the part of the health services to provide said information. It is equally difficult to reconcile how health committee members appointed by the minister can be considered representative of the community, an argument that was often raised by health committee members. The issue of how they can be viewed as independent

when appointed seems to run counter to the MEC's argument that they can only be accountability structures if they retain their independence.

Thus, there is a discrepancy between the rhetoric expressed by actors within the Health Department and the articulation of participation in the Act. This discrepancy resembles the inconsistency displayed during the consultation process, which discussed the Act. During these consultations actors from Department also discussed involvement in high-level issues but ended up with an Act only allowing for involvement in low-level issues and limited decision-making. Overall, it is difficult to see how the vision for health committee participation presented at the meeting is reflected in the Act.

It is impossible to say whether the vision presented in the public rhetoric is the Department's genuine vision of community participation, but it is clear that, if so, it is not in agreement with the provisions in the Act. I posit that the official rhetoric could also be seen as enabling actors in the health services and the Department to officially subscribe to and project an image of health services favouring a substantive version health committee participation, a version that mirrors health committees' vision for participation. At the same time the Department created and implemented a narrower version of participation. This argument is similar to my argument that facility managers could engage in participation and talk about it in positive terms, while at the same time practice a narrower form of participation (Chapter 7). However, the disjuncture between different discourses and the content of the Act could also reflect ambivalence and uncertainty on the part of the Department. It could also be a result of lack of coherence or multiple contested perspectives within the department and power relations within that sphere.

The question this raises is whether health committees accepted this version. The following section looks at that through exploring their reaction to the public rhetoric.

8.3 Health committees' reaction: not internalising rhetoric

Health committees' reactions suggest that many health committee members did not view the public rhetoric as a reflection of the Department's true intentions. The criticism of the process

voiced by health committees attending the meeting in Worcester echoed that of the consultation process, described in Chapter 5. Health committees talked about the implementation as a process that 'ticked the boxes' and requested to be treated 'as we are being part of the process'. Questions were raised as to whether protests would result in a better response: "The government didn't go out to the people to consult … Why must we always toyi-toyi to make things happen", asked one participant, a common question reflecting the view that protests seemed more effective in eliciting a better response. Not much had changed in the Department's engagement between the meeting at Lentegeur and the meeting in Worcester.

The meeting illustrated how contentious issues around participation raised during the consultation process prior to the adoption of the Act remained unresolved. Examples include questions about appointment, capacitation, funding of health committees and the envisioned linkages between various health structures.

It is clear that the projected image of a Department supportive of a substantive form of community participation was not accepted by the health committees at the meeting. To use Haugaard's framing: they did not confirm-structurate this image. Had they done so, this could have been considered a form of invisible power, but instead health committees resisted this rhetoric. Rather, they openly questioned the discrepancy between the rhetoric and the Department's actions. These tensions also played out between the Department and the two health committees in this study, as the next section shows.

8.4 The relationship between health committees and the Department

In the beginning of the fieldwork period, the urban health committee spoke about the relationship with the provincial Department of Health and the minister in positive terms. They perceived the minister as reaching out to communities and inviting engagement. However, this view changed somewhat with members saying that the Department was not really interested in community participation, a change that occurred after members became more aware about the content of the Act and began to reflect on their participation.

At times the urban committee was encouraged by improvements in the relationship, such as being invited to community engagement meetings. At other times they felt disillusioned with how actors from the Department's approached health committee participation. They often expressed dissatisfaction with the way the health services engaged with health committees. Neliswa's assertion that "The Department is not really keen to work with communities" is illustrative. Similarly, Beatrice's comment that the Department is "not comfortable with community participation" could be viewed as a reflection of the contrast between the public discourse and the actions of actors from Department's. In particular, health committee members often felt that the Department did not understand how to engage communities or facilitate engagement, such as through addressing practical concerns such as transport to events. An example of this was a community meeting organised to discuss solutions to frequent attacks on ambulances in the area. Several health committee members attended the meeting, but there was a general feeling that the Department was ill-prepared for the community engagement. This led to expressions such as 'the Department is holding the meeting for themselves'. The chairperson of the urban health committee argued that the current lack of support from the Department's side was a sign that they are not really keen to work with health committees.

The rural health committee complained of a non-existent relationship with the wider health services and the Health Department. In general, the committee did not receive invitations to meetings. Despite many attempts at contacting the Department and despite identifying collaboration with higher structures in the health services as a prerequisite for meaningful participation, the health committee had experienced silence from the health system, something that left the committee rather despondent: "Do they even know we exist?" Laurie asked. With reference to the committee's attempts to seek engagement around the extension of the clinic, he argued:

> The issue is that the Department of Health has not been very accommodating. There is the expectation that we must have meetings … We get ourselves deeply involved. But there is no response or accountability from the Department. The health committee has tried to engage with the Department but has had no response. We have sent letters and submissions. (Laurie)

Both committees hence described limited trust in the Department of Health's commitment or ability to engage with health committees. This contrasts with the Department's public

rhetoric. It is possible that the change reflected health committees being more comfortable about expressing their views later in the research period.

This section has shown that health committees' relationship with the Department was complex and that health committees had limited belief in the Health Department's intentions with regards to participation. In the following section I will illustrate through two narratives how health committees experienced invited participation. This serves to illustrate the discrepancy between the Department's rhetoric and the lived experience of health committees and as a backdrop for understanding their changing views on invited participation.

8.5 Two narratives: health committees' experience of participation

Two narratives often repeated encapsulate how the two health committees experienced participation and how these experiences resulted in changing views of participation. The narrative in the rural committee was dominated by expressions such as 'we are stuck', 'we are going nowhere', 'we meet for nothing' and 'we are on one broken leg'. In other words, this was a narrative of disempowerment and limited influence, reflecting feelings of alienation and marginalisation. Limited influence was also reflected in statements such as the health committee being viewed merely as a 'talk shop'.

In the urban health committee, a narrative of the health committee 'doing wonders', a narrative of empowerment and influence, was dominant in the beginning of the research period. Given the description of how much influence the two health committees had, it is not difficult to understand why the urban committee was more optimistic about its contribution than the rural one was. However, a negative narrative similar to the narrative in the rural committee began to appear later in the fieldwork period. This was a narrative of being more disempowered, unrecognised and unsupported. The sentences that were used repeatedly to express those feelings included: 'they are playing with our feelings', 'they are using us', 'they are really excluding us'. "These people use us when it suits them. They don't even recognise us," said Nonzwakazi. "They are going to play with us and our feelings and divide us," argued Beatrice. "We never received any acknowledgement. Only time we received acknowledgement was around the removal of the shacks. Nothing else," reflected Nkosi. The incident he referred to was a joint effort between the health committee and the facility to

facilitate the removal of informal shacks close to the clinic, which were perceived to be a health hazard.

The emergence of the narrative of disempowerment highlights the precariousness of the health committee's current situation and their everyday experience of operating in a constricted space. This script consisted of frustration and disbelief in participation and in particular in power-holders' intentions with regards to creating participatory structures for substantive participation. It was linked to the urban health committee's feeling that 'things move without them' and the partial form of participation, described in Chapter 7. It resonates with the urban health committee's perception of being 'invited' to a form of participation that takes place on the health services' terms, expressed in sentences such as 'singing to their tune' or 'dancing to their beat'. Perhaps it is best summarised by the following quote from Priscilla: "They [the Department] use health committees, wants them to move on their terms. If the Department say dance, health committees must dance." Hence, this alternative narrative reflects the challenges they experienced with participation, described in Chapter 7. Nonzwakazi commented in relation to complaint management that the health committee is a "Mickey Mouse leadership that dances when the music is on."

The urban committee vacillated to some extent between the two narratives, reflecting that at times they felt invited participation was possible, at other times they viewed it negatively. At the same time, there was an overall move toward the negative narrative during the course of the fieldwork period.

There are several ways of understanding the existence of the two narratives in the urban committee. One is to see the two transcripts in the context of a shift from the positive to the negative narrative, a shift that I argue coincides with the health committee beginning to question the quality of their participation and the nature of their involvement. However, the shift is not complete. I suggest that this reflects complex experiences of participation. The co-existence of the two narratives reflect that participation is experienced both as a positive contribution and as being disempowered.

Scott's (1990) notion of public and hidden transcripts offers a different analysis of the two narratives. Scott posits that oppressed people do not internalise their powerlessness – as many other theories of power argue – but rather that their powerlessness creates a public transcript

and a hidden transcript that co-exit, one in the public sphere, the other in a social sphere to which the dominant group does not have access. The public transcript is a narrative suitable to be uttered in the public domain as it is non-threatening to traditional power-holders. The hidden transcript is an outlet for resistance. It incorporates those feelings and opinions that cannot be uttered in the public sphere. The idea that different and seemingly contradictory narratives can co-exist is useful to understand the existence of two narratives in the urban committee. The positive narrative could be viewed as the public transcript, the negative as a hidden transcript. It can be considered hidden because it was not a discourse that was uttered publicly but expressed in the research setting and only well into the research period, when participants may have felt more comfortable about expressing their views to the researcher. However, it was not entirely hidden as more powerful actors such as the Upper Structure chairperson would confront the health system more directly. As such, his utterances can be viewed as expressions of resistance when the hidden transcript breaks through to the public domain. It is also possible that the emergence of the negative narrative is a result of tacit knowledge becoming discursive.

Overall, I suggest that the two narratives reflect the existence of contradictory experiences, but that there is an overall change in how the health committee views its participation. They may also reflect the existence of hidden and public transcripts or be viewed as a reflection of an ongoing transformation of tacit knowledge to discursive knowledge.

The two narratives crystallise the experience of participation and explain why the public rhetoric of a health system supportive of a substantive form of participation is questioned. The experiences reflected in the narratives are the background for understanding health committees' reaction to the implementation of the Act. In previous chapters I have argued that health committees believed in the invited space; they valued engagement as constructive and perceived protest as destructive. But at the same time, they find the Act and their practised experience of invited participation challenging. This resulted in ambivalence about invited participation. It is in the light of this ambivalence committee members considered the space. This will be explored in the following section.

8.6 Exploring the independent claimed space

The urban committee began to explore alternative spaces to invited appointed participation shortly before the provincial minister sent out invitations for nominations of health committee members. This occurred when they were exposed to the idea of claimed participation as an alternative way of forming health committees.

The event that let to these reflections took place in Cape Town in December 2017 at a meeting where health committees in Cape Town gathered to discuss reviving their umbrella body (the CMHF). An international visitor, who is a social participation activist, gave a presentation in which he shared his experience from his country. He emphasised that the organisation he worked for did not work with health committees appointed by the government, as they believed they were inefficient in holding the health services to account and in advancing the rights of indigenous people, who suffer multiple axes of discrimination in that country. Rather, the organisation trained and supported independent health monitors.

The arguments for independent participation struck a chord with Nkosi and Yeliswa, who represented the urban health committee at the meeting. At the following health committee meeting Nkosi reported back to the committee. With enthusiasm, he explained that the health committee could decide to become an independent structure. Nkosi felt that the creation of an independent structure could offer a solution to the issues health committees face as appointed invited structures.

> It has happened where [the activist] came from. The government appointed health committees, but communities said: we will have independent health monitors. The same thing can be done here. The minister will move with her project [establishing appointed health committees]. The health committee will move with us and can become independent. (Nkosi)

The insight that being appointed was not the only avenue open to them was important to Nkosi. He realised that the health committee could also get its mandate and power from representing communities. Nkosi argued:

> He [the activist] highlighted that it is not a must that they [health committees] are affiliated to governments. They can be independent. An individual from the community can come and check services. It does not have to be a health committee member. (Nkosi)

Nkosi also explained that an independent health committee could hold the health services accountable, whereas it would be difficult for an appointed structure to hold the minister to account. "He [the activist] also touched base on the fact that it would be rare for a person who is appointed to hold the minister accountable. It is much easier for a person who is independent," argued Nkosi. Health committee members agreed that the independent space was worth exploring. The importance of the envisioned independent structure was that it would get its power – what could be considered countervailing power – from the community:

> [The MEC] must be told that she can do her appointments. But the health committee will continue what they are doing with a mandate from the community. She is moving with her own terms. The people she appoints, they can work on their own… but we have been given a mandate from the community. (Xholisa)

The independent space can be considered what Gaventa (2006) calls a claimed or created space. However, when I asked the health committee about what kind of space they envisioned, they talked about an independent space, getting its mandate from the community, but still a space that worked collaboratively with the health services. The significance of this is that it is not considered a 'protest' space such as the space that health committees conceptualised themselves in contrast with. Instead, it was seen as a space that was independent from the Department of Health, but which still valued a collaborative relationship with the health services.

The idea of an independent structure gained traction in the urban committee, though it was agreed that they would wait and see what would happen to the Department's appointments of health committees.

Considerations of becoming independent structures also emerged amongst the health committees in the entire sub-district, where the urban committee was based, as well as in other health committees in the Cape Town metropolitan area. This reflects increasing opposition to the form of participation the Department envisioned and growing interest in a form of independent participation. The exploration of an alternative form of participation can be viewed as evidence that when there is limited influence, citizens may explore realising their health citizenship in different ways. Limited trust in the health services and the

disagreement about how to conceptualise participation let to reflections on whether claimed or independent participation was preferable.

In the rural committee, which was not exposed to the same idea of an independent space, opposition to appointed participation did not lead to the same exploration of creating an independent structure. However, the possibility of alternative spaces, primarily protest spaces, were always considered in this committee, with committee members considering a more 'robust approach'.

The choice between creating an independent claimed space or participating in the appointment process took centre stage as the Department called for nominations of health committee members. The following section will explore this process.

8.7 Implementation: choosing between invited and participation

Shortly after the discussion on becoming an independent structure, 18 months after the Act was passed and nine months after the provincial health minister had told health committee members about the power they would have as appointed health committee members (described in Chapter 5), the process of nominating health committee members began. The minister sent out letters to facility managers explaining the process. It became clear at that stage that the minister had delegated the responsibility of managing the nomination process to facility managers. At the same time, the Department informed the public about the process through advertisements in community newspapers, radio and on the Department's webpage.

In the urban committee a box was placed in the facility's management hub. Interested individuals could submit their nomination forms in the box, but besides that there was no communication to the wider community about the nomination process. Long before the nomination process began, the facility manager at the urban clinic had indicated that he was happy to continue working with the current health committee, and the health committee was keen to continue with the addition of some new members to fill vacancies. From the facility and the health committee's side, it was a relatively closed process of identifying candidates with limited community input. This highlights that health committees may be formed through a process with limited community input in the appointment model. The rural committee was

unaware of the nomination process and received no information from the facility manager regarding the process.

Opinions on whether to accept appointed invited participation or embrace independent participation shifted somewhat in the urban health committee when implementation began. As the nomination process began, the urban committee chose a pragmatic approach to appointed participation, as the following comment suggests:

> [The MEC] can come to us and appoint us, it is going to be fine, and it is not political. But if she comes with her own people, we will appoint an independent structure. Even if she does not appoint us, we can still serve, we get our mandate from the community. (Nkosi)

The Upper Structure opposed the appointment process and indicated that they would initiate processes to elect health committees in the sub-district. The issue of how health committees should be formed had been discussed between the urban health committee and the Upper Structure at a meeting months before the provincial minister called for nominations. The Upper Structure shared this view and its chairperson indicated that health committee members who were appointed by the MEC were considered to be acting 'against' the community. The Upper Structure told members not to send their nomination forms.

The relationship between invited and claimed participation was also debated in the Upper Structure. While the structure initially considered boycotting the appointment process, the chairperson later began to consider participating in the nomination process. However, he was adamant that the Upper Structure would simultaneously engage in creating independent structures, created by community organisations. The rationale for considering participating simultaneously in invited structures and in independent claimed structures was a belief participation had advantages in having a community mandate and being independent, but at the same time a presence in invited appointed health committees was useful as it provided a seat at the table and access to influence.

An independent space can be considered a particular type of space, because health committees view it as being collaborative but independent, because (a) it is not being appointed and (b) it does not derive its power from the state, but rather from the community.

The question to ponder is whether such a form would have sufficient countervailing power through claiming to have a community mandate.

For the urban health committee appointments to become health committee members became an opportunity that led to their abandoning the creation of an independent structure – at least for the time being. Health committee members' motivation for seeking appointments was not only influenced by their motivation to serve as community representatives but was also linked to perceived benefits in the form of a transport allowance (which they often referred to as a stipend). There was substantial anger that they despite their contribution risked being replaced by new members who would be appointed and 'get paid', referring to the transport allowance that the Act allowed for: "Mr C [the facility manager] said he does not need any other clinic committee than us, that is why he demanded that he needs our CVs. But the health committee feels that the Upper Structure closed the door for us to be appointed and get paid," said Nkosi. The issue of 'payment' highlights the health committee members' socio-economic status and how livelihood issues impacted on their decision-making.

The implementation process was not completed at the end of this research. The urban committee continued functioning, while they awaited the implementation. Having considered how health committees considered different spaces for participation, the following section will expand on the relationship between different spaces for participation.

8.8 Invited, claimed and independent participation

At the beginning of the research process there was a clear distinction between invited and claimed participation in the urban committee. I have argued that this changed as the committee experienced invited participation as limited and were concerned with appointed participation. It highlights that invited spaces do not automatically allow for forms of participation that are effective and influential. Fung and Wright's (2003c) argument that more powerful participants may choose other avenues if their interests and views do not prevail in the deliberative forums can be extended to participatory spheres. This may explain the TAC's decision to leave health committees. It may also explain the urban health committee's deliberations on whether to form an independent structure.

Moreover, as argued in Chapter 6, formal institutionalised participation seems to be stronger when it co-exists with other claimed or independent spaces, as these spaces function as a form of countervailing power outside the space. The existence of different spaces for participation enables actors to consider where they have most influence. The existence of alternative space can also result in increasing health services' willingness to engage with health committees.

In Chapter 6 I described how engagement between these different forms of participation changed as local TAC members and the SACP chairperson were approached to become health committee members. This points to the possibility of collaboration between different spaces, which could strengthen citizen voice.

Thus, different forms of participation could be viewed as different forms of citizenship that strengthen each other and can be chosen strategically in different contexts. Invited participation may be considered a possibility, but actors consider other forms of participation if their experience of invited participation does not allow for real influence and they have alternatives. They may choose creating independent structures, which may have more countervailing power and more influence.

8.9 Conclusion

In this chapter I have argued that there is a discrepancy between the official rhetoric of participation as it is presented by actors from the provincial Department of Health and the Act's conceptualisation of participation. Health committee members questioned the public rhetoric and did not accept it. This contributed to tensions between health committees and the Department. I have illustrated how health committees' lived experience of participation were reflected in two narratives, one of disempowerment and one of empowerment. I contended that the first narrative is strongly prevalent in the rural committee, while the two contrasting narratives co-exist in the urban committee, though there was a shift towards the narrative of disempowerment over time. This took place as the urban health committee began to reflect on the quality of their participation and how much – or little – influence they had. I have contended that these narratives provide a backdrop for understanding the decisions the urban health committee made with regards to participation.

The chapter argued that health committees' reaction to the implementation process should be understood in the light of their understanding of the Act, their experience with the consultation process (Chapter 5) and their experiences with practised participation (described in Chapters 6 and 7). Furthermore, it argued that their reaction should also be viewed in the light of the official rhetoric around participation and how this compared to the provisions of the Act and their lived experience of participation.

This resulted in the urban health committee considering undertaking independent participation, believing this would give them more influence. However, as the implementation process began, they decided to engage with the appointed invited process. Other structures, such as the Upper Structure, adapted their objection to invited appointed participation by also considering how these spaces could co-exist and strengthen community voice. I have argued that citizen participation seems to benefit from different spaces that can be used strategically to maximise community influence. Choosing spaces for participation is a strategic choice but is also influenced by livelihood issues.

9 Discussion: the possibility of invited participation in the health system

9.1 Introduction

This discussion draws together the findings and analysis and relates them to debates about participation. The overall question this research asked was how power impacts on health committee participation and their ability to provide community input and exert influence in health governance. Linked to this, it considered whether invited participation is a viable form of engagement between citizens and the state and its institutions. The question is asked in a context where new participatory forms of engagement between citizens and the state have proliferated in South Africa, but also in a context where claimed forms of engagement between citizens and state have surged. The discussion on the possibility of invited participation should also be seen in the context of the contradictory research on invited participation. For instance, Katsaura (2015), Williams (2007b) argue that invited spaces can be spaces devoid of real influence or of pseudo-participation. These scholars are sceptical of the value of invited participation and argue that the proliferation of social mobilisation through protest can be seen as evidence that invited participation has failed (Tapscott 2007; Thompson and Tapscott, 2010; Katsaura, 2015; Sinwell, 2015). This should, however, be seen in contrast with scholars that view participation as an option under the right conditions. The main proponents of this view are Gaventa (2004, 2006) and Cornwall and Coelho (2007). Gaventa stresses the importance of viewing participation as an expression of citizenship, while Cornwall and Coelho link the possibility of participation to a number of preconditions including how participants view themselves and the design of the participatory space, reminding us of the importance of distinguishing between different forms of spaces and conditions. Scholars studying Brazilian community participation in health, which proposes that these structures do have influence, should also be seen as a contrast to the South African studies suggesting that invited spaces allow minimal influence.

The current study's findings and analysis could be viewed as evidence that invited participation results in limited influence. The analysis has demonstrated how health committees' influence is limited and constrained by many forms of power, though it has also showed that health committee members drew on enabling forms of power and displayed

agency aimed at improving and expanding participation. Significantly, the analysis has shown that invited spaces are not homogenous, but rather that there are many forms of invited spaces such as appointed invited participation, organisational-based invited participation and self-appointed invited participation. Conditions for these spaces vary. In addition, the discussion contemplates a form of invited participation not practised in the health system in South Africa: structures based on elections. Hence, the question of whether invited participation works is re-framed to ask when it might work, and in particular which model might work and under which conditions.

The chapter is structured in the following way. I start by summarising the findings and analysis of the research. This is followed by a discussion of the empirical research, presented in four sections.

a) First, I discuss different models for health committee participation as well as conditions under which invited participation may be a viable option. Given the importance of countervailing power, I explore the sources and strength of countervailing power in the different models. Linked to this is a discussion on alternative sources of countervailing power. The different models are also considered in terms of how representative they are and to what extent they allow for diverse and inclusive representation.
b) Second, I discuss how to design a space with sufficient influence and power based on the conceptual frameworks outlined in Chapter 2.
c) The third section discusses strengthening participation through paying attention to various forms of constraining and enabling power in legislation and practice.
d) The fourth section reflects on the reasons for the health services' ambivalent response to participation.

The discussion of the empirical findings and analysis ends by indicating that invited participation is a possibility under certain conditions. The discussion then considers the implications for the conceptual and theoretical understandings of participation and power, respectively. The discussion ends with reflecting on implications for policy and practice before outlining the study's limitations.

9.2 Summary of findings and analysis from Chapters 5 to 8

The first findings and analysis chapter (Chapter 5) suggested that the invited space created for health committee participation in the Western Cape Province of South Africa is an ambiguous, contested and 'unstable' space that health committees find constraining. There is no agreement on what constitutes health committee participation between those who created the space and those who are invited to participate. In particular, the system of ministerial appointment is viewed as incongruent with health committee members' understanding of participation. Furthermore, health committees were concerned with their roles, which are weaker both in comparison with roles in other provincial policies and with national policies. These roles do not resonate with theoretical understandings of participation either. Additionally, there were concerns that the limited support for participation will impact negatively on health committees.

I suggested that legislation can provide participatory structures with countervailing power that enables members to participate and have influence, but this depends on the content of the said legislation. While the Act may provide countervailing power in the form of an official mandate, this power is restricted by forms of constraining power embedded in the Act. Through adopting the Act, the Department projects an image of being serious about fulfilling its obligation to promote participation, while at the same time the content of the Act restricts the promise of substantive participation. Furthermore, participation was conceptualised as a privilege rather than a right, something that inherently entails limited countervailing power. The consultation process leading to the adoption of the Act was experienced as disempowering, with minimal community influence in designing the participatory space.

The second findings and analysis chapter (Chapter 6) explored the organisational - community-led - model, where community representatives are chosen by community organisations. The urban committee in this study used an organisational model (or stakeholder model), where organisations elect the health committee. The rural health committee preferred this model but was unable to implement it as a result of limited stakeholder interest, leading the health committee to be composed by interested individuals. Preference for community-chosen representatives was based on arguments that they would better represent and be accountable to communities. Health committees' claim to legitimacy was linked to them being representative of and accountable to the communities they reside in.

In the urban site several challenges to this claim emerged. There were challenges that they were unknown and therefore not representing the community. Relatedly, there was a charge that they were not accountable to communities as they did not have formal feedback meetings. The urban committee's effectiveness in addressing community issues was also questioned. Hence, both their substantial and instrumental legitimacy was questioned.

In the rural committee the main issue related to representivity and accountability was disengagement by potential stakeholders. In both committees, a relatively closed formation process further weakened their claims to being representative committees. The chapter argued that a claim to have a community mandate could be viewed as a form of countervailing power. Hence, when such a claim is challenged, so is health committees' countervailing power. The chapter ended with considering whether sufficient countervailing power can be generated through other sources such as the more adversarial community structures and it described signs of such collaboration.

The third findings and analysis chapter (Chapter 7) explored practised participation in the context of limited countervailing power. Using the conceptual understandings of participation, it contended that the current practice was limited in terms of degree of influence in decision-making, role and level of participation and thus not in agreement with a PHC approach to participation. It argued that health committees had the ability to identify community issues. Sometimes these were articulated and led to a response from health services. At other times their participation was partial, based on what the health services chose to involve them in. I showed that often their participation was characterised by many 'missed opportunities' for bringing community views and concerns to the health services. The limited participation was partly a result of a number of constraining forms of power. These include management of information and collaboration with facility managers as two important forms. Lack of confidence, capacity, knowledge, skills, resources, collective action and commitment further constrained health committees' agency. These forms of power, in conjunction with health committees' limited countervailing power, enabled health officials to encourage participation, but at the same time control it in ways that significantly limited committees' influence. This research bore out Fung and Wright's argument (2003c) that participation suffers without sufficient countervailing power. Simultaneously, health committees attempted to expand their participation and displayed agency, drawing on enabling forms of power. They derived enabling power from a rights discourse, critical

consciousness, reflective practice, and in the case of the urban committee, strong links to other organisation, primarily the Upper Structure. Occasionally, manifestations of collectivity, confidence and new skills enabled agency.

The last findings and analysis chapter (Chapter 8) described a discrepancy between the public rhetoric expressed by actors from the Department of Health, which valorises community participation, and health committees' actual experience of participation. It highlighted two narratives of health committee participation. It suggested that the rural committee largely framed its experience as one of disempowerment. In contrast, the urban committee vacillated between a narrative of empowerment and a narrative of disempowerment. I argued that the two narratives existed simultaneously in the urban committee and reflect contradictory experiences, though the narrative of disempowerment became more dominant. This occurred simultaneously with the committee questioning the quality of their participation and their influence. Taken as a whole, health committees' experience of invited participation can best be described as ambivalent. The chapter suggested that they began to consider alternative spaces for participation such as a claimed independent space as a result, something that took place as the Department of Health began to implement the Act. The chapter highlighted that health committees did not internalise the health services' public discourse, but rather displayed critical awareness of how it was in conflict with both the legislation and their experience of practised participation. Thus, invited institutionalised participation remains an option, but whether participants choose to engage in it depends on a number of factors, not the least of which is where they perceive they have most influence.

9.3 Discussion on findings and analysis

9.3.1 Different models for health committee participation

This research used a framework of closed, invited and claimed spaces. An important contribution of this study is the argument that different forms of invited participation all entail different conditions for participation that impact on their potential. In particular, I have highlighted two different forms of invited participation: appointed (top-down) and community-led (bottom-up) participation. Community-led participation occurred through organisation/stakeholder representation as well as through self-appointed representation. As

the self-appointed model was not favoured by any of the committees participating in this study, it will not be considered further.

A related finding is that the potential of these different forms of participation is linked to how much countervailing power committees have and the source and strength of their countervailing power. Appointed participation, for instance, should be considered different to community-led participation because it gets its legitimacy and countervailing power from different sources. Despite this, there has been little attention to where representatives get power from in invited spaces.

While this research did not study appointed participation in practice, it is an important form of participation to consider as it is the form envisioned in the *Western Cape Health Facility Boards and Committees Act 2016* (2016) and many other South African provincial policies. Appointed participation derives its countervailing power from the person who appoints the committee, in this case the MEC. Ultimately, health committee members are therefore accountable to the MEC.

At the same time, they are being nominated by and representing communities and being accountable to these communities. To what extent being nominated by community structures, but being appointed by the MEC, will impact on who they ultimately perceive themselves to represent and be accountable to remains to be seen. However, it is clear that top-down appointments were opposed by health committees, because they argued that appointed people may not necessarily represent communities. Hence, such structures could according to health committees not be considered legitimate structures. On a related point, they argued that appointed health committee members were unlikely to be able to hold the health services accountable.

The system of appointment is a model of invited participation where power – by design – lies disproportionately with the health services. Moreover, the implementation process, which began during the research period, showed that this model can lead to a closed formation process, which is likely to result in poor representational links to communities. Such a process can also lead to structures being 'captured' by well-connected and organised individuals and organisation such as SANCO, which dominated the urban committee. This reflects Head's (2007) argument that participatory spaces can be captured by elites and by

extension by groups of people able to assert themselves. It can therefore be considered inconsistent with theories about participation that stress the need to give a voice to those not normally heard (Hilmer, 2010). On a similar note, it is worth considering Piper's (2015) point that in cases where spaces are 'captured' by political interests, they become on extension of the state rather than a means to expand participation and make it more inclusive.

The research has emphasised the need for strong linkages between health committees and communities. The effect of poor linkages was evidenced in this study and is also reflected in other research on health committees (Boulle, 2007; Padarath & Friedman, 2008; Glattstein-Young, 2010; Haricharan, 2012). The appointment model appears not to strengthen these links.

The second model to be discussed is the organisational model practised in the urban health committee. In this model health committees' potential source of countervailing power came from their claim to represent communities and get their mandate from these communities. However, in practice their countervailing power was weak because of challenges to their legitimacy and claims to have a community mandate. Hence, for organisational community-led participation to be able to generate sufficient countervailing power, they would need to strengthen links with communities and community organisations through, for instance, improved accountability mechanisms and improved representational links. Nonetheless, a challenge inherent in the model remains: the model only allows for organised sections of the community to elect and compose health committees. A major challenge for this model is therefore how to ensure a more inclusive, diverse and broad-based composition. It is difficult to see whether this is possible. The model also relies on a formation process where local powerholders may be able to capture the space and establish the committee in a relatively closed process, which in turn can result in a risk that participation becomes an extension of the state rather than a mechanism for more inclusive participation – such as with the appointment model.

The third model to consider is an election model, where health committees are elected by people residing in a clinic's catchment area. Residents would be eligible to stand for election and elect health committee members. This model is not practised amongst health committees and is not envisioned in the Western Cape Act or other South African provincial policies. However, an election model was envisioned in *The White Paper on Transformation of the*

Health System (Department of Health, 1997), and the *Western Cape Draft Policy on Health Governance Structures* (Western Cape Department of Health, 2008). It is also practised in other South African participatory structures such as school governing bodies and ward committees. Internationally, elections are said to be practised in Kenya (Shani, 2009, quoted by McCoy, Hall and Ridge, 2012),[29] while participatory structures in Peru have some elected members (Iwami and Petchey, 2002), though it is uncertain who constitute the electorate. A democratic election model is widely discussed. For instance, Walter Flores, director of the Centre for the Studies of Equity and Governance in Health Systems in Guatemala, argued for democratic governance and elected health committees at a regional meeting on community participation with participants from East and Southern Africa, Guatemala, India and the United States held in Cape Town (Mdaka, Haricharan & London, 2014). His position was widely supported at the meeting. Williams, in the context of South African health facility boards, also argues for elections rather than appointments as a way of broadening representation and participation (Williams, 2007a, 2007b).

Given the difficulties health committees face in generating sufficient countervailing power, it is worth considering whether this model would provide more countervailing power. An elected representative would be able to claim to be representing those electing him/her, be accountable to the electorate and through this claim legitimacy. Thus, in terms of countervailing power, an election model may provide better prospects for invited participation. The advantage of an election model would be that it would be open to all sectors of the community. Furthermore, one of the early scholars of participatory democracy, Macpherson, argues for elected representative as a precondition for democratic participatory structures:

> What is needed, at every stage, to make the system democratic, is that the decision-makers and issue-formulator elected from below be held responsible to those below by being subject to re-election or even recall (MacPherson, 1966:109).

However, the strength of the countervailing power would depend on how many community members participated in elections and on the extent to which the process was considered

[29] It has not been possible to locate the original source for this information.

open, transparent and inclusive. Strong community linkages remain important for this model as it was for the organisational/stakeholder model.

Despite the issues with the organisational model, health committee members were not in favour of elected structures. Some urban health committee members claimed community elections were unfeasible because of the size of the catchment area. Another reason for their resistance was that health committee membership was also linked to certain personal benefits, such as social status in the form of being able to claim to be a community leader, and economic benefits, such as access to job opportunities and possibly financial resources in the form of a stipend or a transport allowance. Moreover, I have also argued that the organisational model allowed certain groups to control the process.

The organisational model may be preferred by health committee members and organisations to the election model for a variety of reasons. The model of appointing health committees, on the other hand, is favoured by the health services and the Department because it gives them control over participation. The appointment model favours those who have connections to broader structures of power and to political parties. An election model where the population in the catchment area constitutes the electorate would likely favour those citizens who are powerful in the local community, as does the organisational model. Further research should explore different models, including where they get countervailing power from and how well they can be considered to represent communities and be legitimate.

In this section I have argued that the presence of countervailing power relates to how health committees are formed and where they get their legitimacy from. However, countervailing power can also come from other sources available to participatory structures such as legislation, which is discussed in the following section.

9.3.2 Legislation as a source of countervailing power

Fung and Wright (2003c) suggest that a policy is a potential source of countervailing power. Many South African papers and reports have called for legislation on health committees (Boulle, 2007; Padarath & Friedman, 2008; Glattstein-Young, 2010; Haricharan, 2012; Abrahams, 2015; Zwama, 2016; Chikonde, 2017). They argue that having a legislated

mandate is important for effective and meaningful participation. This case study took place in a context where the *National Health Act* created a legislated space for health committees, but the mandate was only consolidated with provincial legislation in 2016. A key finding from this research is that legislation can be viewed as a precondition for effective participation, but that it is not sufficient to ensure it.

There are several points to be made about legislative frameworks from this study. It is clear that having a legislative framework provides health committees with a mandate and that this was viewed as giving health committees some form of countervailing power. However, the content of legislation determines how much countervailing power the legislation confers to health committees. I have demonstrated that many other forms of power in the Act restricted health committees' substantive participation and their countervailing power. This include how committees are established, their roles and how participation is supported. A legislative framework for participation can through its content create a form of participation that limits influence and leave control largely with the health services and the Department. When the legislative framework is created without community input, as was the case here, it can result in a form of participation that takes place on the health services' terms.

Furthermore, the Act frames participation as a privilege rather than a right, because power is disproportionately situated with the Department and health services through the way the Act is worded in terms of issues such as access to information and roles. There are few obligations on the health services. When legislation frames participation as a privilege rather than a right, and makes it conditional and contingent, this undermines health committees' power. This means that health committee members cannot make claims as claims-holders, but only from a position of seeking privileges.

While legislation pertaining specifically to health committees fail to provide a framework for substantial participation, it is important to note that public participation is a constitutionally enshrined right. Thus, it can be argued that the current provision for participation in health does not carry out the constitutional provisions for participation.

9.3.3 Rights-based participation

Conversely, conceptualising participation as a right could provide health committees with countervailing power because it positions participants as claims-making agents and the state and its institutions as duty bearers of rights. Hence, a human rights framework for participation would entail that participants have a form of power that could be considered countervailing power.

An important aspect of a human rights framework is that the state has an obligation to put in place mechanisms for participation. It, thus, reframes the state's responsibility in relation to participation (Hunt & Backman, 2008). As suggested by Potts (2008a, 2008b), a rights-based approach to participation could be strengthened by the existence of an oversight body that could deal with issues related to participation, monitor implementation and provide guidelines. The urban health committee members' insistence on the importance of monitoring how the Act would be implemented resonates with Potts's view on oversight and monitoring. In the South African context, the Human Rights Commission could be a body with the legitimacy to oversee that participation takes place.

Conceptualising health committee participation with reference to the UN's *General Comment 14,* (UN Committee on Economic Social and Cultural Rights, 2000) could also provide a framework for health committee legislation based on rights as it recognises the right of individuals and groups to participate. Furthermore, it outlines participation as entailing influence in decision making in setting priorities, planning, implementation and evaluation (UN Committee on Economic Social and Cultural Rights, 2000:ss54). One way of strengthening formalised participation is through creating legislation. Such legislation would be strengthened if it was based on a rights framework. The right to participation is considered a supra-normative right. Legislation that draws on a human rights framework would therefore acknowledge the elevated priority of participation in human rights law and strengthen participation.

Overall, I suggest that structures that are legislated, based on human rights and formed via community elections may provide for the most optimal conditions for participation as such structures would get countervailing power from legislation, from a human rights framework and from a legitimate community mandate.

In this section I have shown how conceptualizing participation as a right might provide countervailing power; in the following section I address the question of whether adversarial community structures are another potential source of such power.

9.3.4 Countervailing power through collaboration with adversarial structures

This study has argued that countervailing power can also be generated through collaboration with other spaces and structures. The power that the urban committee derived from the Upper Structure is an example of this. It is in essence a form of collective power because this structure is constituted by health committees in the sub-district.

Furthermore, the urban committee derived countervailing power from the fact that there were alternative forms of engagement outside the participatory space. The primary way in which this happened was through influencing health services to collaborate with health committees. Their existence communicated to the health services that there were structures with more adversarial tactics outside the invited space. In that way they indirectly presented the health services with a choice between collaboration with the invited participatory space or perceived adversarial participation, including through protests. This resonates with the *Powercube* and Cornwall and Coelho (2007), who argue that mobilisation outside the space is important. Piper and Nadvi (2010) similarly contend that meaningful participation in invited spaces requires the support of strong civil society (outside the invited space). While these researchers refer to mobilisation outside the space which support participation, the study presented here suggests that even when there is no social mobilisation that supports health committee participation, such as was the case in both committees, the very existence of alternative structures such as the TAC and the SACP impacts on health committee participation. In contrast such structures are absent in the rural committee. The rural committee does not have strong links to community structures and there are no strong alternative structures, which can hold the participatory structure 'open'.

A second way in which these claimed spaces may provide countervailing power is through entering the invited space and fostering collaboration between (adversarial) community structures and invited participatory structures. This could confer countervailing power to the

invited space. This study demonstrated nascent signs that this was a possibility as these structures negated the invited-claimed, collaborative-adversarial divide and tested participation in different spaces. Fung and Wright (2003c) are sceptical about collaborative forms of participation getting countervailing power from adversarial structures, though they do consider it a possibility that local forms of adversarial countervailing power can be (slowly) transformed. The different cognitive frames, which Fung and Wright view as a hindrance to collaboration, may not be insurmountable in this context as the TAC members considered joining the urban health committee and the health committee approached the SACP to join the committee. A potential common cognitive frame could be a human rights frame. A rights course, which health committees drew on, is also fundamental to the TAC (Geffen, 2010; Mbali, 2013). The health committee did not deliberately seek to generate countervailing power through collaboration with these structures. It is clear that while the urban health committee benefitted from these organisations, their countervailing power would be strengthened if they consciously considered how collaboration and mobilisation could result in generating more power.

It is also important to bear in mind research, which argue that people negate different spaces for participation. For instance, a study in Cape Town's biggest township found that people engage in different spaces. While they prefer deliberative space, they may also engage in protest (Thompson & Nleya, 2010). This indicates that the invited-claimed dichotomy is not so rigid in this context. Similarly, the TAC can be considered an organisation that operates in both claimed and invited spaces and use both collaborative and adversarial tactics.

An important question this raises, then, is whether invited participation is stronger if these more adversarial structures enter the invited space or if they remain outside the space. This is a complex question. However, it is clear that having different spaces available enable actors to choose between different forms of engagement depending on which one is more effective. Engagement between different spaces strengthen community voices and their countervailing power. Thus, rather than seeing invited spaces in opposition to created/claimed spaces, these could be viewed as different forms of citizenship that can be chosen strategically in different contexts. The chairperson of the Upper Structure's contemplation on whether there should be both invited and independent health committees reflects such a view.

9.3.5 Politicians as a source of countervailing power

Another potential source of countervailing power, according to Fung and Wright (2003c), is politicians with a vision in favour of participation. Fung and Wright are not clear on how politicians generate countervailing power, but this would likely be through putting in place legislation that supports participation. It could also be through the vision they imbue with their support and impart to actors within the health services. By extension, one might also consider whether administrative structures such as the Department of Health could be a source of countervailing power. In Chapter 8 I argued that the Department and the MEC have two conflicting discourses of participation. Hence, in this context the Department is at best unclear about its vision and the version of health committee participation it is committed to. This is exemplified by the Department talking about high-level influence but creating an Act with low-level influence. Consequently, it is difficult to see how politicians or the Department in this context can be considered as offering a form of countervailing power.

Tapscott argues in the context of urban governance that political neglect did not cause invited participation to fail (Tapscott, 2010). In other words, he implies that there was political will to implement participatory structures. In the context of health committee participation, I suggest that this may not be the case. Rather, legislation was crafted in such a way that power remains disproportionately with the health services. Though the Department shows willingness to implement participatory structures, the type of participation envisioned in the Act is inconsistent with conceptual understandings of participation and there is limited support for participation. Yet it is important to note that powerful actors within the health services can and do function as important leverage points for change. For example, managers in the sub-district improved the urban health committee's access to information and expanded their role to include involvement in staff meetings through directives to local actors. Similarly, facility managers can support a more substantive notion of participation.

Compared to Fung and Wright this study has showed that countervailing power can also come from links to other organisations as well as from a human rights conceptualisation of participation. Moreover, the study has linked the presence of countervailing power to different models for establishing participatory structures. Additionally, the study has shown that in this context collaboration between adversarial and collaborative structure may be possible, and that there are common mental frames that can be useful in these collaborations.

In this section I discussed how health committees can generate sufficient countervailing power. Moreover, different models should also be evaluated in terms of how their formation process and composition ensures that they represent communities. The following section will discuss this.

9.3.6 Community representatives

The concept of a community representative is important in health committees. Health committees' objections to the appointment model were based on representatives not being perceived as representing communities. Few research papers deal with how people become 'community representatives': i.e. how they come to represent others. This is particularly the case for research on participatory structures in health. When representation issues are dealt with, the focus is more on categorising groups who participate, e.g. by gender, age and educational attainment, and less on how some people come to represent others, the processes leading to this and the implications of this. The concept of a community representative reflects the fact that those participating in these structures represent others. Participation is therefore not open to all or all-inclusive but occurs via representation. An important finding from this study is the need to pay theoretical and practical attention to what a community representative is and how this is reflected in different models of community participation.

The model of appointment as it is envisioned in the Western Cape Act relies on organisations in the community to nominate people to represent the community. Based on these nominations, the MEC or a person appointed by her will chose community representatives. While it is unclear how the process would unfold, facility managers were tasked with managing the nomination process and, according to the urban facility manager, the MEC had indicated that she would seek advice from them in appointing health committees. Hence, in the appointment model the health services and the Department determine who should represent communities. The current health committees object to this model on the ground that communities should choose who should represent them. The organisational model is based on community organisations choosing community representative but, as argued, this model may omit sections of the population that are not organised, and there is a risk that the process can be captured by organisations and groups. The election model may be more open, but there is

limited evidence on how such a model would work in practice. Again, strong organisations or groups may be able to capture the process.

Principles of inclusivity and diversity should also be considered when considering different models as inclusive and diverse representation is key in participation. Inclusivity is mentioned in the conceptual frameworks, but there is no detail on how to ensure inclusive representation. In the Western Cape legislation there are provisions for diverse gender, age and racial representation as well as consideration to disabled people, but no further provision for marginalised groups is considered. In practice, there was no attention to principles of inclusivity or diversity evident in the composition of either committee. The organisational or stakeholder model appears in its very design to be favouring organised sections of the community – and related not be concerned with diversity and inclusivity. In comparison, the election model would allow for non-organised citizens to become representative, but the model is not designed to guarantee diversity and inclusivity. Legislation – irrespective of whether it envisions appointed, organisational or elected health committees – could contain mechanisms for ensuring diverse and inclusive committees. Further research on how inclusivity and diversity would best be accommodated in different models is needed.

Cornwall and Coelho (2007:15) note that the literature on representation suggests that there is a strong argument that a direct democratic approach where participation is open to all can best ensure the inclusion of less organised groups. However, whether such a model is feasible is questionable.

9.3.7 Considering the claimed independent space

This research has argued that health committees became ambivalent about invited participation, both as it was outlined in the Act and as it was practised. One of the main reasons was the limited influence promised in the Act and experienced in practice. This ambivalence resulted in considerations of whether to engage in invited participation or to create alternative independent spaces. The ambivalence also influenced health committees' decisions with regards to participating in the implementation of the Act.

William's (2007b) argument that people often choose not to participate because they do not believe it will produce meaningful results, and Fung and Wright's (2003c) assertion that people choose other avenues if their interests and views do not prevail reflect that actors make strategic choices with regards to different spaces. This is also evidenced in the urban health committee's discussions on whether to create an invited space or accept appointed participation.

Furthermore, actors from the urban Upper Structure reflected on how participating simultaneously in the appointed invited space and creating an independent space for participation. This demonstrates a flexible, pragmatic and strategic approach to invited and participation. It remains to be seen whether health committees will choose this approach and with what result.

Importantly, the independent space they considered should be viewed as an alternative to the more traditionally conceptualised claimed space, which often draws on an adversarial relationship with the state, as it was conceptualised as a space that would work collaboratively with health services, but from a position of independence.

The research has shown that rather than accepting the Department of Health's vision of participation, health committees consider what options they have. They critically evaluate the potential of participatory spaces and consider how to maximise their influence. Hence, the existence of different spaces strengthens participation, because it gives participants options and enables them to choose a space with sufficient countervailing power and influence. This resonates with Thompson and Tapscott's (2010) argument that rights need to be claimed both through conventional forms of participation, but also through protest action. Similarly, von Lieres (2007) contends that participation thrives when it takes place in multiple spaces and through multiple practices.

In the previous section, I have discussed the importance of countervailing power and influence and how health committees consider different spaces for participation based on which space offer them most influence. In the following section, I will discuss whether using key aspects from the conceptual frameworks could be used to design health committees as effective participatory spaces.

9.4 Using conceptual frameworks to design participatory spaces

Influence in decision-making is a key principle in the conceptual understandings of participation with many models measuring various degree of influence (a case in point being Arnstein's (1969) ladder). How the space created by the Act will be actualised is impossible to say, but the Act provides for minimal input in decision-making. Rather, the Act is silent on how decisions are made and what decisions health committees can be part of, if any. Hence, there is a risk that the invited space becomes a space of minimal influence. Similarly, the case studies showed that health committees have limited decision-making power in their practised participation. This finding is consistent with much research on health committees (Loewenson et al., 2004; Glattstein-Young, 2010; Haricharan, 2012; McCoy, Hall & Ridge, 2012). As noted by McCoy and colleagues, participation generally occurs along the lower rungs of Arnstein's (1969) ladder.

This thesis has argued that people make strategic choices with regards to whether to engage in invited or participation. When participants have neither power nor influence, they may become disillusioned with the process. This was borne out in this study, where in particular the rural committee lamented their limited influence. Moreover, participants may consider alternative forms of realising their health citizenship and engaging with the state. The surge of claimed participation and protests in South Africa despite a proliferation of invited spaces could be a result of these spaces offering insufficient influence. The recurring question raised by health committee members about whether communities needed to toyi-toyi to be heard could be viewed as a claim that the state only responds to protests. Thus, designing spaces where participants have influence is one way of strengthening invited participation and make it a viable option.

Health committee roles are as important as influence in decision-making as it obviously matters *what* participants have influence over. Clarity on role and function has been identified as a major factor impacting on health committee participation (see for instance, Padarath & Friedman, 2008; Glattstein-Young, 2010; Haricharan, 2012; McCoy, Hall & Ridge, 2012). Neither the Act nor practised participation involved much involvement in

priority setting, planning or implementation – in health governance.[30] The study demonstrated that health committees had much useful knowledge that could be translated into input in the planning and implementation of health services, and so looking at ways to use that knowledge to improve health care could be valuable. Authors such as Creighton (2005) and Head (2007) argue that it is local knowledge that make participation effective.

Furthermore, it would be worth considering a function that is absent from the conceptual understanding, namely roles that ensure accountability. The human rights framework talks about evaluating strategies, which can be considered an accountability role, though the role is not elaborated on and specified in relation to community participation. Even though many studies describe community monitoring (E.g. Bjorkman & Svensson, 2009; Garg, & Laskar, 2010; Khunte & Walimbe, 2012;) through mechanisms such as score cards, there is not much literature focusing specifically on health committees as accountability structures. Molyneux and colleagues (2012) found limited empirical evidence that health committees' play a role in accountability, but they and Cleary, Molyneux & Gilson (2013) suggest that it could potentially be an important role. Involving community structures in community accountability has become an avenue considered by some authors as a possible way of enhancing and complementing bureaucratic accountability mechanisms (Potts, 2008b; Molyneux et al., 2012; Cleary, Molyneux & Gilson, 2013). This thesis concur with this view.

Neither does the issue of accountability feature in the Western Cape Act. This reflects a shift from the *White Paper on Transformation of the Health System* (1997) and the *Draft Policy on the Health Governance Structures (*2013), where it was included. In practice, accountability was an important function for the urban health committee. Their complaint management role was one they performed relatively well. In general, both communities viewed themselves as structures that would hold health services to account. Involvement in accountability is a promising role, and its potential should be explored and researched further. A similar point was brought forward by an urban health committee member, who argued that having a structure outside the health services ensuring accountability was preferable to leaving accountability mechanisms solely to the health services.

[30] Training material on how to involve health committees in the annual planning process has been developed by the Learning Network (MacQuilkan, 2015), suggesting ways in which they can play a role in planning.

Influence in policy is considered an important role in a human rights framework but is not reflected in South African policies on health committees, including the Western Cape Act. Again, the *White Paper on Transformation of the Health System* (1997) differs from the Act in that it stipulates the need for provincial and national summits to discuss policies. While participation in policies does not necessarily have to take place through health committees, it is worth contemplating how they could have input into policy processes. This may be through a tiered structure or through a national structure. South African health committees have expressed the need for a national network to take up issues with a broader purview (Naidoo, 2017). Here it is also worth looking at Brazil's health system, which offers an alternative way of structuring community participation in health compared to South Africa. In that country participation is organised through municipal health councils and policy health conferences, which start at a very local level and take place at various levels ending with a national policy conference (Cornwall & Shankland, 2008). Representatives are elected through a series of stages starting at the very local level. While it is a complex matter to compare two health systems, it is worth considering Brazil's model in terms of ensuring community input in policy processes. More attention should be given to the way that participatory structures, including health committees, could have input in policy.

The discussion on involvement in policies reflects another important principle in the human rights and PHC frameworks, namely that participation should occur at different levels of the system from local, to national, to international. While this does not mean that the same structures should participate at all levels, it is worth considering how health committees could have input on other levels of the health system. The Western Cape Act says that the MEC should promote collaboration between structures, but there is no articulation of links between health committees and structures such as hospital boards or district health councils. There are also no community participation structures at sub-district, district, provincial and national level. The importance of having access to higher levels in the health system was emphasised by the rural committee. The *White Paper on Transformation of the Health System* (1997) and the *Draft Policy on Health Governance Structures* in the Western Cape (2008) are examples of policies where a tiered structure is envisioned. Given that Brazil's participatory system is considered to have contributed to the country's improved health (World Health Organization, 2008), and given that South Africa's re-engineering of primary health care services was based on the Brazilian Family Health Programme (Pillay & Barron, 2011) this model of

invited participation is promising. A tiered structure may lead to a more comprehensive system that would allow for influence and community input at different levels.

An important point in the Alma-Ata Declaration is that people should be educated to participate. The case studies reflected this principle by demonstrating the importance of people's confidence, skills and capabilities for participating and suggested that training could play a role in improving these. Additionally, I argued that not facilitating participation can be considered a form of hidden power, which sets participation up for failure. However, this study has also suggested that the educative principle is not sufficient but should be extended also to entail active facilitation and support, including through the provision of adequate resources. Numerous studies have outlined barriers to heath committee participation. Lack of funds and resources has been identified in studies such as the South African studies mentioned above (Boulle, 2007; Padarath & Friedman, 2008; Glattstein-Young, 2010; Haricharan, 2012) a Tanzanian study (Kamuzora et al., 2013) as well as two Kenyan studies (O'Meara et al., 2011; Kilewo & Frumence, 2015).

A starting point for creating a participatory framework in the health system in South Africa that is consistent with conceptual understandings of participation would be a return to the *White Paper on Transformation of the Health System* (1997), which views participation as an extension of democracy. This policy document envisions a system with elected representatives, substantive roles including influence on policy, and a form of participation that entails national, provincial and district health summits.

This section has shown how policy and practice can be improved through considering the conceptual frameworks for participation, but creating effective participatory space also requires attention to different forms of power. The following section will consider this question.

9.5 Improving participation through attention to power

Attention to power in both policy and practice can potentially improve participation through creating spaces conducive to participation. This study has outlined many forms of power that impact on the policy and practice of participation. Understanding the ways in which

constraining forms of power influence participation could be an important step in mitigating these forms of power. Similarly, understanding sources of countervailing power and forms of enabling power could be useful in enhancing these forms of power.

The role of facility managers and other medical professionals has been raised in many studies (Boulle, 2007; Padarath & Friedman, 2008; Glattstein-Young, 2010; Haricharan, 2012), including studies that highlighted top-down decision making (Kessy, 2014) and facility managers' limited knowledge about of participation (Zwama, 2016). This study adds a further dimension by suggesting that facility managers' engagement with health committees was manifested through different forms of power. Management of information and collaboration, in particular with regard to their availability, significantly influenced participation as did their support and attitude to participation. Furthermore, as the Act had not been implemented, they also exercised discretion in deciding the health committees' roles. In that sense the research supports Fung and Wright's (2003c:264) argument that when service agencies are open to broader participation, professionals can still protect their prerogative if participants do not have sufficient countervailing power. An alternative explanation could be that facility managers are not sufficiently capacitated or resources to engage with participatory structures. Understanding facility managers' role in participation and their understanding of participation is an important area for further research.

With regards to information management, acknowledging the right to information as a right linked to the right to participation in the Act would be an important step. Providing clarity on what type of information health committees have a right to have access to would help facilitate participation.

The most important form of invisible (internalised) power was health committee members' lack of confidence in speaking up and raising issues. The imbalance in power created by lack of confidence was exacerbated by health committee members' socio-economic marginalisation and limited educational background. Health committee members' capacity to participate has been identified as an issue in numerous studies (Kapiriri, Norheim & Heggenhougen 2003; Boulle, 2007; Padarath and Friedman, 2008; Haricharan 2012; Kessy, 2014, Zwama, 2017). Conversely, the presence of confidence, which health committees sometimes expressed, could be considered an enabling power, a 'power within'. Confidence should then be viewed as a precondition for effective participation, as its presence results in

the manifestation of voice and agency. Training that is designed to build confidence may help to address this issue, as training has been shown to improve both confidence and capacity (Haricharan 2015b; Chikonde, 2017). Training could also be designed to address power dynamics.

I argued that not ensuring that participants are able to participate can be viewed as a form of hidden power. It is evident that participants' marginalised socio-economic status, including their limited educational background, is an underlying factor. Health committee members are often marginalised citizens and are inherently at a disadvantage in terms of their ability to participate. This makes capacitation and support crucial to level the playing field. This support should include other forms of support that redress obstacles to participation such as lack of resources, which is mentioned in many studies on health committee participation (see McCoy, Hall & Ridge, 2012). It is in this light that I propose that conceptual frameworks for participation should expand the notion that education is important to also include other enabling factors such as resources and support.

There was increasing awareness of how lack of collective action undermined the urban health committee's power and functioned as a form of hidden power. By the same token, the presence of collective action could be considered a potential enabling power, a 'power with', as it can provide health committees with agency. There were examples of how collective action, such as approaching the facility manager as a collective, improved participation. Considering how to enhance collectivity could be an important point in participatory structures, an issue that could, for instance, be taken up in reflective spaces.

Health committee members also drew on enabling forms of power and displayed agency. The most prevalent form was linked to their view of themselves as rights-claiming citizens. They believed in their right to participate and had an evolving notion of a substantive form of participation that entailed them acting as accountability structures that made claims of the health services and held it to account. Viewing themselves as having a right to participate and conducting themselves as rights-claiming citizens provided them with important 'power within'. When combined with collective power ('power with') this resulted in agency. It was through drawing on these enabling forms of power that health committee members became agents that challenged current practices, attempted to expand their participation and considered what type of participatory space to engage in. This could be viewed as a reflection

of Cornwall and Coelho's (2007) claim that participatory agents need to be able to recognise themselves as citizens.

Reflective practice was important as it resulted in health committees' critical engagement, which in turn resulted in agency when combined with other forms of enabling power. Their changing perspectives on participation, on their role, their relationship with the Department and the facility managers could be viewed as a consequence of these reflections. For instance, it was clear that collective reflections led the urban committee to question the quality of their participation and raise issues with the facility manager. Training designed to facilitate reflective practice may be particularly useful in this regard. Using critical Freirean[31] adult education principles could be explored. However, reflective practice could also take place outside of traditional training. I have shown how some research activities became a space for reflective practice. Other spaces for reflective practice could be developed by health committees or other stakeholders such as supportive facility managers, co-ordinating structures such as the Upper Structure, or organisations partnering with health committees such as the Learning Network or the Cape Metro District Health Council. Thus, capacitation programmes could be designed to address both capacity and confidence issues and ensure ongoing reflective practices. In conceptualising reflective practice, it would be worth considering how this could facilitate the transformation of tacit knowledge to discursive knowledge. Moreover, the Powercube and VeneKlasen's understanding of forms of power could be useful tools for enhancing critical reflection on power and participation.

An important point to note is that there was limited evidence of internalised negative beliefs impacting negatively on health committee participation. In the main, it was not internalised beliefs but other forms of power that constrained participation. This resonates with Scott's (1990:91) argument that constraints come from power in everyday life rather than internalised beliefs.

[31] Here I refer to Paolo Freire, the Brazilian advocator of critical pedagogy.

9.6 Response of health services

Health services' view on participation is an important determinant for how effective health committees are and how much influence they have, in particular when health committees have limited countervailing power. The following section focuses on how health services responded to participation and discusses possible reasons for their response. When I talk about health service response, I talk about the engagement at local level between health committees and facility managers, and about the Department's approach to participation.

The study demonstrated two different responses to participation from facility managers, with the urban manager taking a more collaborative approach, while the rural manager was less collaborative. Despite both facility managers talking positively about the concept of participation and in case of the urban facility manager, also about the actual committee, both health committees had a prevailing impression that facility managers feared losing control and felt threatened by participation. The perceived attempt by facility managers to control participation was viewed as a result of this. The fact that unit managers withdrew from health committee meetings when the urban committee was trained was also viewed as an indication of them perceiving participation as a threat.

It is often assumed that unequal power relationships between laypeople and officials will somehow be mitigated in the participatory process and that officials will automatically and willingly relinquish power (Cornwall & Coelho, 2007). However, Cleary and colleagues (2013) remind us that pressure from superiors to improve performance can impact negatively on health managers' attempts to respond to citizens as they focus on other demands rather than on engaging with citizens (Cleary, Molyneux & Gilson, 2013). This could also be the case for facility managers' engagement with health committees – that other duties are prioritised to the detriment of health committee engagement. Similarly, Lodenstein et al. (2017) outline a number of factors that impact on how health providers respond to communities and citizens when they claim social accountability. These include providers' expectations of the role of users in accountability, their perception of how legitimate these groups are, providers' feeling of support and appreciation, fear of repercussions, their moral obligation and their self-perceived capacity and identity. A case in point in relation to this study is the rural facility manager's perception of the health committee as a structure that lack

legitimacy and is deemed to be useless. This in turn impacts on how she responds to the committee.

One should also bear in mind that the policy context is confusing, with different conceptualisations of roles in, for instance, the *Ideal Clinic Manual* and the Western Cape Act, two policies that facility managers would be requested to implement. It is difficult to see how both could be implemented as they contain very different roles.

Furthermore, it is unclear whether facility managers themselves have the capacity to engage in participation even though they are at the immediate interface of it. The urban manager indicated that he had not been capacitated. Hence, their collaboration with health committees could reflect an inability to facilitate participation rather than be an expression of power. It is perhaps understandable if they are uncertain about participation. Considering what kind of support facility managers would need to become effective in participatory spaces would be useful. A study conducted in Cape Town demonstrated how training of facility managers in understanding community participation impacted positively on their intention to engage more meaningfully with health committees (Zwama, 2017). Facility managers and health professionals' increasing interest in participation is evidenced by the fact that the University of Western Cape's Winter School course for health managers on community participation has seen an increase in participants. The first year, in 2016, six people signed up; in 2018 the course had 25 participants (Nikki Schaay, personal communication, 11 November, 2018). More research into understanding facility managers' and health managers' views, experiences and ideas about participation would be useful. This would also be valuable for future practical work with health committees and could be an important avenue for strengthening participation.

In terms of the wider health services, there was a discrepancy between the public rhetoric and the way participation was practised and conceptualised in the Act. The first was a discourse of substantive participation, the other demonstrates a limited conceptualisation of participation. Furthermore, by not supporting or facilitating participation the health services at large demonstrate limited commitment to participation.

Health committee members reflected in numerous situations on the seemingly ambivalent and dissonant response to participation from actors in the Department. Similarly, there were

consistent questions around whether the only way to engage with the Department was through protests (see Chapter 6), a question that resonates with debates on which form of participation is most effective.

There are several possible explanations for the Department of Health's response. It may suggest that actors in the Department are ambivalent or uncertain about what form participation could take. Bearing in mind the literature, which contends that participation can have a different purpose to the one stated publicly, one should also contemplate what purpose participation has for health services in this context. Thompson (2007) and Williams (2007b) argue that participation is about legitimizing decisions, while Fung and Wright (2003c) argue that participation can result in state-shrinking. Katsaura (2015) argues strongly that the participatory space is about allowing people to vent to defuse tensions.

The Act's roles of fundraising for the clinic and encouraging volunteerism could be viewed as signs that health services associate participation with shrinking state responsibility. Much research does indeed indicate that health services often view participation as a way of getting people to volunteer or raise additional resources. Often health committees are seen as an extra pair of hands at the clinic (see, for instance, Haricharan, 2012). This is not surprising, given the strain many health services, particularly in the developing countries, including South Africa, find themselves under. Volunteering and fundraising may be ways for communities to contribute to health services. However, participation in health governance should not be equated with volunteering or fundraising. If participation is conceptualised in this way, it can be considered an expression of shrinking or shifting state responsibility by turning users into providers rather than rights-claiming agents, to paraphrase Dagnino (2005).

This study did not present direct evidence that the health services or the Department used health committee participation to legitimise decisions, but there were incidences where the urban health committee was called upon to support the health services.

Neither did the study provide evidence that participation was an outlet for defusing tensions, such as Katsaura (2015) suggests. Certainly, there was a lot of venting of emotions, in particular in the rural committee, where frustrations with health services were often palpable, but rather than release tensions, the venting exacerbated them. I posit that shrinking state

responsibility, venting and legitimising decisions were not the main motives for the Department's approach to participation.

Instead, I suggest that the Department's response reflects a preference for invited participation over a more adversarial engagement. This is consistent with Head's (2007) view that participation can minimise the desire for protests. By engaging with health committees, the health services can claim that these are the legitimate community structures for engagement. I have also shown that there is a perception that the Department and its political head prefer invited to claimed participation. However, while the health services prefer invited participation, they prefer it in a form where they control it and set the conditions. It is in this light that health services' ambivalence should be viewed. The Department presents a view of participation that is acceptable to health committees but implements a form of participation that is on the health services' terms.

Another explanation could be related to the purpose of participation. Scholars have identified two models for participation in health: a) a target/utilitarian model; and b) an empowerment model; (Oakley, 1989; Morgan, 1993; Pretty et al, 1995). In the utilitarian/target model the focus is on how participation contributes to strengthening health services and helps to meet health-related targets. In this thinking it is easy to think about participation in terms of assisting the health services in a practical way, such as is evident in much research on participation. This is the case for many of the studies where participation occurs 'at the lower rung' of Arnstein's (1969) ladder. Here the quality of participation and the degree of influence is not the primary concern. Instead, the focus is on outcomes, which can be achieved in different ways and may not be seen to rely on influence in decision-making. In contrast, the empowerment model's main objective is empowering participants. However, both the content of the Act and practised participation have shown that empowerment is not the primary objective for the health services. In fact, this research has shown that at times participation was disempowering, as was the case with the consultation process before the Act was promulgated. This suggests that empowerment may not be a goal for the health services and the Department.

Moreover, I argue that the dichotomy between an instrumentalist and an empowerment framework should not be viewed as an absolute dichotomy. Rather, a democratic approach and an empowerment framing of participation could also serve instrumentalist goals. An

assumption behind a participatory democracy approach is indeed that it leads to better decision-making (Creighton 2005; Head, 2007). This research has provided examples of how community input and knowledge can contribute to the health services, for instance, around understanding reasons for defaulting, people refraining from seeking health care, and mediating between a biomedical health system and other health systems. The primary reason for this is that it relies on local or citizen knowledge. One could also ponder over whether a form of participation that conceptualises participatory structures as oversight and accountability structures could be viewed as leading to instrumentalist goals by improving health service delivery and patients' trust in the services.

How participation is viewed is linked to the values and vision of key actors. Research which focuses on understanding participation from the perspective of other actors in the health services would be useful. Thus far the discussion has focused on lessons from the empirical data. In the following section I reflect on what the research can contribute to the conceptual frameworks used in the study.

9.7 Discussion of implications for conceptual frameworks

The study has highlighted that the conceptual frameworks could be used to structure community participation and has suggested that in particular a human rights framework provides a strong basis as it situates participants as rights-claiming citizens and through this provides countervailing power. It can be considered a framework that allows for the development of health citizenship. Interestingly, health committees' view of themselves as rights-claiming agents was an enabling form of power. Hence, a rights framework provides both countervailing and enabling power.

While all frameworks consider the principle of inclusivity important, there is not much attention to the best way that inclusivity can be assured. This is something that should be contemplated in the different frameworks.

The case study pointed to the importance of considering what a community representative is and the process through which actors come to represent others in participatory spheres. This should include reflections on how to ensure inclusive representation. Further, the

representation of marginalised citizens, understood as citizens who would otherwise be excluded, is important.

A linked issue is ascertaining how participatory structures become legitimate, representative and accountable structures and how they get sufficient power to become effective in the participatory sphere. Conceptual frameworks pay limited attention to this. This research suggests that frameworks could be strengthened through considering these questions.

The study was framed around three different forms of participation: closed, invited and claimed spaces. However, the case studies showed that within these categories there are a multitude of potential spaces. In particular, I argued that two distinct forms – appointed and community-led invited participation – carry very different promises and have suggested that it is imperative to understand the conditions for different forms of invited participation. A central concept has been that of countervailing power, a form of power that participants can draw on to enforce participation. Participatory frameworks should consider how models and frameworks ensure sufficient power for participation to be effective.

The cases illustrated that health committees could play an important accountability role. Accountability is not considered in the conceptual understandings of participation – though the human rights framework talk about evaluations. I suggest that accountability should form part of the frameworks as part of conceptualising participation as participation in health governance. Finally, the study proposes that conceptual frameworks' view of education as necessary for participation is important, but not sufficient. It suggests that enabling factors such as resources and support should be considered as important as education and added to the human rights and PHC frameworks.

9.8 Discussion of implications for power frameworks

Lukes's and the *Powercube's* understanding of power provided a useful starting point for exploring power in participation. However, it was also evident that the *Powercube*'s framing of power was insufficient to explore the complex ways that power and agency operated. VeneKlasen and Miller's enabling forms of power complemented the *Powercube*'s constraining forms of power as their framework acknowledges the constraining forms but

views them as co-existing with their three forms of enabling power. Another avenue to agency is through addressing constraining power through tacit knowledge becoming discursive. I have focused on Haugaard's way of expressing this, but it is also implicit in the *Powercube*. The thesis suggested that this transformation could take place through reflective practice, which played an important role in health committees' agency. Reflective practice improved confidence, something that can be considered a form of 'power within'. It also improved collectivity, a form of power that can both be considered a countervailing power and an enabling form of power ('power with'). Both constraining and enabling forms of power should be viewed as points for change. An important point to note about the *Powercube* is that where it depicts beliefs as a form of constraining power, an internalised power, this study suggests that beliefs can also be a source of enabling power, in particular beliefs in human rights and citizenship.

The thesis juxtaposed Scott's (1990) theory with the *Powercube*'s notion of invisible and internalised power, leading to an analysis which suggested that internalised beliefs were not a strong form of power.

Scott's (1990) understanding of power was useful to understand how people may respond to dominant hegemonic ideologies not by internalising them, but with resistance, even though this resistance may not be public, but take place in a hidden space. While I have found Scott's (1990) theory useful to understand how health committee members responded, I also suggested that it is possible that people respond to hegemonic discourses in different ways. I contend that some may internalise beliefs, while others may resist them. Some may internalise some beliefs and resist others. People may initially internalise them, but through the processes I have described as turning tacit knowledge into discursive knowledge may resist them. Thus, it is possible that internalisation and resistance may be different ways of responding to dominant ideologies.

I have used Fung and Wright's (2003a) concept of countervailing power extensively. Countervailing power can be considered a form of power that ensures that the health services engage in community participation. I view countervailing power as a form of power that is equivalent to having a mandate or a right to participate. It is through countervailing power that participants can claim their right to participate and expect health services to engage in participation.

According to Fung and Wright (2003c), collaborative countervailing power is likely to come from policies/legislation or from politicians. In addition, they concede that local mass mobilisation based on adversarial countervailing power could possibly be transformed into collaborative forms. This research has suggested that this is possible. It has demonstrated that the adversarial-collaborative dichotomy is not so rigid in this context and that there may be common mental frames such as a human rights framework. Furthermore, the research has presented evidence that there are other avenues to collaborative countervailing power than those proposed by Fung and Wright. These are mainly linked to how participation is conceptualised, and the model used. Finally, countervailing power also came from links to other structures, namely the Upper Structure. This could be viewed as a form of collective power.

I have argued that two forms of power are necessary in collaborative invited participation: countervailing power which often comes from external sources, and enabling power, which promotes participants' agency. I have suggested that neither is sufficient on its own.

An important lesson from this thesis has been how the exploration of power through different theoretical lenses has added to a more nuanced approach to understanding the way power operates in participation. Hence, I propose that using the *Powercube*, VeneKlasen and Miller's framework, Scott's theory, Haugaard's notion of power as well as Fung and Wright's concept of countervailing power has contributed to enhancing an understanding of the operation of power in relation to participation.

The many different lenses through which power has been explored also has implications for strategies on how to address the different manifestations of power in participation. Firstly, the notion of countervailing power should be considered, in particular in how it relates to the way that power is 'organised' in designs, frameworks and legislation. Secondly, it would be useful to draw on the *Powercube* and VeneKlasen and Miller's frameworks to design frameworks that are supportive of participation, enable agency and address constraining forms of power. Haugaard's and Scott's understandings of power provide useful frames of references to develop an understanding of how to enhance agency through facilitating the translation of tacit knowledge into discursive and consider the conditions necessary to transpose hidden transcripts into the public arena. The different theoretical frameworks have also been useful

to discuss how agency occurs through resisting dominant ideologies, through transforming tacit knowledge to discursive knowledge and from drawing on sources of 'power within', 'power with' and 'power to'.

9.9 Implications for policy and practice of participation

This research has highlighted that there are many tensions and contradictions in the policy landscape related to health committee participation. The first initiative to formalise health committee participation in South Africa came with the *White Paper on Transformation of the Health System* (1997). This policy paper contained a vision for health committee participation that is largely in consonance with the conceptual understandings outlined in this thesis in viewing participation as being about influence in priority setting, planning and implementation of health services. The White Paper (1997) considers health committees to have an accountability role, a role I have argued could be potentially important. The policy paper also talks about elected representatives, a model I have argued may confer more countervailing power to health committees. Moreover, it envisions involvement in policies and health summits to take place at national, provincial and district level. The *Draft Policy on Health Governance Structures* (2013) - some two decades later - has a similar substantive notion of participation. Though the *National Health Insurance Policy* (2017) refers to this policy, its pronouncements on health committee participation is not in agreement with it. The Western Cape Act on health committees presents a substantial departure from the *White Paper on Transformation of the Health System*, the *Draft Policy on Health Governance Structures* and the *Ideal Clinic Manual*, in particular in terms of how roles are envisioned. A recommendation from this research is to use the conceptual understandings presented in this thesis and the 1997 White Paper to create or amend health committee legislation. Additionally, I suggest that national and provincial legislation should be aligned to a single comprehensive legislative framework.

An important point from this research is the demonstration of the importance of ensuring an enabling environment for participation in health committees. Legislation should pay attention to this. I have suggested a more substantive notion than just educating health committees to participate, as this is insufficient to sustain participation. Important aspects of enabling participation are adequate resources and support.

Finally, this research has argued for the importance of considering how power is expressed in policies and legislation. It has argued that legislation can potentially be an important source of countervailing power, but that depends to a large degree on the content of legislation. The *Powercube*'s authors' comment that policy makers "need to take power into consideration if they are serious about participation" (Powercube, 2011:71) rings true in this context.

For the health system and services, the main lesson is that participation needs proper frameworks, proper support and attention to the operation of power. A particularly important lesson is that, without influence, participation may take a form that is unsatisfactory for health committee members and community members and they are then likely to seek alternative forms of engagement or disengage. Actors in the health system can do much to facilitate a substantive form of participation even when legislative frameworks are not conducive to this. The urban case revealed how a collaborative facility manager worked with the health committee, even though the collaboration was at times complex, at other times there were efforts to expand participation. Similarly, the urban case showed how actors at sub-district level could support participation and be leverage points for change. In contrast, the rural case illustrated how a facility manager with a negative view of the health committee did not facilitate participation.

For health committees, the analysis of power can be useful to strategize around how to address constraining power and enhance agency through drawing on enabling sources of power derived from beliefs, collectivity, commitment and reflective practice. Similar lessons are relevant for civil society stakeholders that work with health committees, such as the LN and the PHM. Contemplating how countervailing power impacts on participation, where different models for participation get countervailing power from and how it can be generated, can help participants be more effective in their participation.

9.10 Conclusion: when does invited participation work?

The discussion of empirical findings and analysis centred on when and what type of invited participation is viable. It has argued that appointed invited participation, while providing health committees with some countervailing power, is inconsistent with participatory

approaches outlined in the second chapter and was rejected by existing health committees. It has suggested that the organisational model could be strengthened to provide more countervailing power and improve links to communities, but despite this the model struggles with ensuring inclusive participation because it favours organised sectors of the community. The discussion suggested that a legislated space, based on human rights and formed via community elections open to all people in the catchment area may provide sufficient countervailing power for participation to be effective. The reasons for this are that it provides a conceptualisation of what a community representative is by suggesting that it is a citizen who is democratically elected to represent community views. I have argued that this may result in more legitimate structures and thus more countervailing power. In addition, the model would get countervailing power from legislation and from a rights framework. Strengthening ties between community representatives and the communities is paramount, irrespective of which model is chosen. The discussion has argued that legislation could be altered based on these frameworks, which are consistent with the vision of health committees in the *White Paper on Transformation of the Health System* (Department of Health, 1997).

The final part of the discussion on the empirical data reflected on the conditions under which invited participation is viable. It used the theoretical frameworks to discuss how to design participatory spaces. An important condition for invited participation to be considered viable is that it should ensure influence. Allowing participants influence in creating the space may provide a space that is embraced by communities and leads to them feeling empowered rather than disempowered. Once created, the space must allow for them to have real influence. The discussion argued that unless health committee members have real influence, they may consider using or generating alternative forms of participation to the invited form currently practised. Using the three conceptual understandings of participation can be useful in designing a participatory space. Here, I have suggested that paying attention to the *White Paper on Transformation of the Health System* (1997) may be worthwhile. Finally, the discussion has reflected on how invited spaces may co-exist with independent or claimed spaces, and that participation is in fact strengthened by different expressions of health citizenship.

Enabling conditions are essential and include mitigating constraining forms of power, enhancing enabling forms of power, and ensuring an enabling environment. Viewing

participation as a way of deepening democracy rather than within an instrumentalist framework may also be useful in creating the space.

Finally, the thesis has shown how using numerous frameworks for understanding power and adopting a nuanced approach to understanding both constraining and enabling forms of power can be used to strategize and enhance health committee members' agency.

9.11 Limitations

There are several limitations to this study, which should be noticed. The fact that I do not speak the vernacular languages is an important limitation. In particular, my inability to speak these languages impacted on observations where people communicated in these languages. In these situations, I had to rely on the translators or people who spoke English. Nuances may have been missed.

The choice of two cases was made to balance the need for depth with some of the advantages of a multiple case study. However, it is evident that the cases were very context-specific and different contexts may have elucidated other aspects. While many of the theoretical considerations have relevance in other contexts, it is clear that the policy context is specific to this study context.

While the research took place over an extended period, it stopped prior to the finalisation of the implementation of the Act. The research showed that the urban health committee and other actors changed their position on the Act, and it is impossible to say whether further shifts will take place in the future. The research may have lost out on important information in this regard. For these reasons, the study cannot be said to have reached full theoretical saturation with respect to this aspect though most concepts can be considered sufficiently saturated.

An important methodological consideration is how the research may have impacted on the health committees. I have, for instance, noted that the focus group discussions became a site for reflective practice. It is perhaps inevitable that long-term qualitative research, which asks

questions, explores topics and revisits events, will lead to reflection. This can be considered a finding, but it can also be considered a limitation.

My literature review focused on English literature and thus may have missed out on important evidence from non-English journals.

10 Conclusion

This thesis explored how different forms of power impact on health committees' participation and their ability to provide community influence in Primary Health Care through a multiple case study with an urban and a rural health committee in the Western Cape Province of South Africa. It also explored whether invited participation is a viable form of engagement between citizens and the state. It looked both at how power was expressed in the *Western Cape Health Facility Boards and Committees Act of 2016* (2016) and how current practices of participation occur and are influenced by power. Additionally, it explored how health committees responded to the implementation of the Act and made decisions regarding what form of participation they chose to engaged in.

A framework of closed, invited and claimed spaces was used to theorise health committees as invited spaces, understood as spaces where authorities invite citizens to participate with officials. Health committees are one of many participatory mechanisms that the post-apartheid state has made provision for in its legislative framework. However, post-apartheid South Africa has also seen an upsurge in claimed forms of participation, often through demonstrations which are sometimes associated with violence.

The thesis drew on participatory democracy theory, human rights and Primary Health Care approaches to conceptualise participation as influence in decision-making in health governance at local, national and international level, with health committees functioning at primary health care facilities. Different understandings of power were used to explore how power can both constrain and enable participation.

The thesis argued that the Western Cape Act on health committees provides for a form of participation that is incongruent with viewing health committees as structures that have influence in decision-making in health governance and that power is disproportionately located with the health service, making health committees' influence limited. The Act conceptualises participation as a privilege rather than a right, which would imply that health committees could make claims as claim-makers.

In practice, participation was partial with limited influence in health governance. Health committees had the ability to identify issues important to health service delivery, but there

were many missed opportunities for community input. Health committee participation was constrained by a number of manifestations and expressions of power: management of information, facility managers' limited availability and collaboration, lack of skills, knowledge and confidence, limited resources, and lack of collective action and commitment.

The thesis argued that substantive health committee participation necessitates two forms of power: countervailing power (which is an external form of power in the form of a mandate or a right to participate) and enabling forms of power (which promotes agency). Enabling forms of power, which health committees drew on include beliefs in the right to health and participation, which made them position themselves as citizens and claims-making agents. In addition, reflective practice resulted in agency as it transformed tacit knowledge to discursive knowledge and promoted critical consciousness. Finally, the urban health committee derived some of its enabling power from association with other structures, first and foremost the Upper Structure and its chairperson. These different forms of enabling power together with confidence, collective action and capacity, which was sometimes present, resulted in agency.

The thesis compared three models of health committee participation and assessed which form provided sufficient countervailing power: the appointment model envisioned in the Act, the organisational model practised in the urban committee, and an election model practised in other participatory structures and envisioned in, for instance, the *White Paper on Transformation of the Health System* (Department of Health 1997), the blueprint for a post-apartheid unified health system. The three models have different ways of generating legitimacy and countervailing power. In the appointment model, this comes from the MEC and the legislation, but because the legislation bestows power disproportionate with the health services and the MEC, it is a limited form of countervailing power. In the organisational model, it comes from a claim to represent and be accountable to the communities they represent, but, as I have described, the committees were challenged in this regard. Stronger community links and improved design could improve this, but the very fact that only organisations can elect and be elected makes for limited claims of broad-based representation. I have proposed that an election model may provide for stronger legitimacy claims and countervailing power. The reason for this is that an elected community representative may be better positioned to claim to represent and be accountable to those electing her/him if elections take place through an open and transparent process. Furthermore, elections are in theory open to all, whereas the organisational model limits

membership to organised sectors of the community. I contended that an election model could both ensure a more open broad-based process for establishing committees and ensure that health committees have sufficient countervailing power. Framing participation as a human right that is operationalised in legislation could further strengthen committees' countervailing power.

Health committees' experience and understanding of the invited space created with the Act and their experience of limited practised participation forms a backdrop for understanding how health committees made decisions about whether to participate in the invited space when implementation of the Act began, or whether to create an independent space. A discrepancy between the health services and the Department's public discourse that supports substantive participation, for instance through arguing for involvement in high-level issues, but at the same time put in place legislation which only allow for limited influence in low-level issues contributed further to their ambivalence. I argued that their ambivalence resulted in committee members considering creating independent structures. People made strategic choices between different forms of participation, partly based on where they have most influence.

Considering the findings and analysis of this research and the contradictory literature on invited participation, I argue that invited participation remains a viable option under certain conditions. Furthermore, whether actors choose this form of participation depends on whether they have sufficient influence and power. One way of creating an effective invited space with sufficient influence would be to create a legislated space based on an election model and based on the conceptual frameworks outlined: a participatory democratic theory approach, a PHC approach, as outlined in the Alma-Ata Declaration, and a human rights framework based on *General Comment 14*. This positions health committee members as legitimate claimholders and the state and its institutions as duty-bearers. Such participatory structures could potentially be more effective, as they would have sufficient countervailing power derived from the legislation, the human rights framework and the legitimacy they would have from a valid claim to representing communities. Furthermore, for effective participation, actors need to consider how to minimise constraining forms of power and promote agency through enhancing enabling forms of power.

Finally, the thesis argues that participation is strengthened by the existence of different spaces – invited and claimed – as this provides actors with options to maximise their influence. Moreover, adversarial structures can provide countervailing power in the sense that they can motivate health services to engage with health committees and the community in invited spaces. Hence, the co-existence of invited and claimed participation strengthens citizen voice and engagement with the state.

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Appendix A: Health committees' roles in governance and oversight in South African provincial policies and legislation

Province	Governance Function	Oversight
Eastern Cape	• Oversee adherence and provision of the primary health care packages. • Identify health related problems in the community for purposes of planning and inform the health facility accordingly.	• Monitor and report on health indicators and targets. • Receive regular report on the performance of facility management in meeting facility objectives. • Monitor how management resolves complaints. • Monitor health facility's opening and closing times. • Monitor the effectiveness of communication between management and communities. • Hold management accountable for implementing decisions taken in committee meetings.
KwaZulu-Natal	• Oversee the administration of human resources, financial resources, assets, facilities and the general affairs of a clinic or community health centre.	• Report any maladministration of a clinic or community health centre to the responsible MEC. • Provide the responsible MEC with bi-annual reports on the performance of clinic and community health centres.
Free State	• Advise the health facility management. • Review and approve local health delivery plans.	• Investigate administrative complaints and make recommendations regarding the solutions of complaints to the District Health Council (DHC) • Investigate health service delivery problems and make recommendations to the DHC.
Mpumalanga	• Support PHC facility management with policy and strategy formulation. • Provide expert advice and inputs to the PHC facility management.	• Monitor the investigation and resolutions of complaints.
Gauteng	• Advise the management on the formulation of PHC facility policies and strategies. • Participate in strategic planning and operational processes with a view to advising the management.	• Fulfil an oversight role with respect to the performance, effectiveness and efficiency including the maintenance of the PHC facility.

	• Ensure that measures are taken by management to improve the performance and quality of services. • Take measures to ensure that needs, concerns and complaints of clients and the community are properly addressed by management.	
Northern Cape	• Ensure that the strategic direction, vision and values of the establishment align with the needs of the community. • Ensure that risks are identified and managed. • Ensure financial sustainability. • Ensure human resources are effectively managed and developed. • Develop systems and processes for internal controls both operational and financial. • Provide oversight and guidance.	• Monitor management performance and compliance with ethical business practice. • Provide oversight and guidance to the health establishment management structure in the following areas: patient and staff safety. •
North West	• Ensure that all clinic committee members are committed and actively involved in all health governance activities • Governance Structures are required to participate in Governance and Management meetings where the following are discussed, planned and remedial action taken; financial issues, human resources, quality of care as well as monitoring and evaluation, organisation risk management. • Ensure that health services are accessible to all community members	• Monitor customer care including staff attitude • Oversee the clinic's procedures with respect to hygiene, and patient safety • Oversee complaints management • Monitor essential drug availability. • Ensure monitoring of health education for community members
Western Cape	• Assist the community to effectively communicate its needs, concerns and complaints.	• Conduct scheduled visits to the primary health care facility, and provide constructive written feedback • Conduct surveys, meetings and consultative workshops in the community/communities • Request feedback on measure taken by the management to improve the quality of services.

Appendix B: Topic guide: Focus Group on Voice, Agency

1. Why does HC not 'follow up'. They have identified this as a weakness. Go through list in nodes. (Probe: Capacity? Apathy? Not believing in results/impact? Lack of recognition? Other priorities?)
2. Why did their voice diminish after training (probe: FM reaction to workshop, staff reaction to LN training)
3. Why does HCs identify issues well, but do not address them as well? (Probe: confidence, skills, organisation issues)
4. "Singing along and dancing to their tune"? Why do HC do that? What forms of power enables others to get them to do that?
5. HC acknowledges that 'they should have voiced better' in relation to Act. What prevented them. (Probe: confidence, knowledge, power, authority.)
6. Why did HC decide not to do anything about the Act? (probe: resignation, beliefs, previous experiences).
7. 'We are heard but not as much as other people" - explore meaning, feeling, reaction.
8. What are they doing about the repeatedly rude nurse? (which they seem not to have raised with the FM). What prevents them from raising it?
9. Have they followed FM's suggestion that they should come and ask questions more frequently.
10. Issues raised/not raised: Zatla, folders, Mr Govender, Grant Issue, Ukutala, rude staff. Why/why not raised?
11. Why are there so many 'missed opportunities' for HC action.
12. Commitment – explore what it is about. Not being at meetings, coming late etc. "Commitment starts with themselves" mentioned many times.

Appendix C: Human Research Ethics Committee's approval letter

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 404 7682 • **Facsimile** [021] 406 6411
Email: posi.tsama@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

18 August 2016

HREC REF: 460/2016

Prof L London
Public Health & Family Medicine
Room 4.42
Falmouth Building

Dear Prof London

PROJECT TITLE: VOICE, REPRESENTATION AND POWER IN INSTITUTIONALISED COMMUNITY PARTICIPATION (PhD-candidate-H Haricharan)

Thank you for your response letter to the Faculty of Health Sciences Human Research Ethics Committee dated 15 August 2016.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th August 2017.

Please confirm that when participant folders are reviewed, any participant that may require further management will be followed up.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval before the research may occur.

We acknowledge that the student HJ Haricharan will be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON. FHS HUMAN RESEARCH ETHICS COMMITTEE

HREC 460/2016

Appendix D: Project information sheet, health committee member, focus groups

Dear health committee member,

Thank you for taking the time to read this letter, which explains the project that I would like you to be part of. The purpose of this letter is to give you information so you can decide on whether to be part of the study or not. But first, let me introduce myself. My name is Hanne Jensen Haricharan. I work at the University of Cape Town's School of Public Health. I am also a Ph.D. student. For the past 6 years, I have been involved with community participation in health and worked with health committees. Health committees are also the topic for my Ph.D. research.

My Ph.D. study looks at community participation in health committees and how effective participation is. It is particularly interested in how well health committees represent and give voice to community needs. It will also look at how different forms of power, understandings, experiences and beliefs may impact on participation. Finally, it will look at how people are able to exert agency to realise the right to health and improve health service delivery. The reason for doing the study is to find ways of improving health committee participation and through this improve health services.

The study period is expected to be between 12 and 18 months. During that period, I will visit the community regularly and observe what happens in the community, at the clinic and during health committee meetings. I will also interview people individually and I will have discussions with groups of people. Towards the end of the study period I will conduct workshops where I will present my research findings and discuss how this can be useful for people that were part of the study. I will organise all study activities in collaboration with study participants – they will take place at a time and a place convenient to you.

This particular information sheet relates to focus groups. Each focus group is expected to last between 1 and 1 ½ hour.

Participation is entirely voluntary, and even if you decide to say yes, you can withdraw your participation as a later stage. You can do this by telling me or informing my supervisor, Professor Leslie London at the University of Cape Town (phone: 0791896368).

You will not receive any money from participating. But if you have transport costs related to being part of the research, I will repay you the money you spent. I will also make sure that we have refreshments for research activities.

I don't foresee any risks for you as a participant. However, it is possible that some of the topics we discuss will cause tension either in the health committee or between committee and health facility. If this occurs and it is necessary to have outside mediators, please tell me so I can organize this.

While there is no direct benefit to you as a participant, I believe there are many indirect benefits. You may learn about how health committees function and how they could function better. You may become aware of things that limit your health committee participation and the impact the committee have on health service delivery. In the end, this could be used to improve health services. There could also be benefits to other people in the health system, such as facility managers, other managers and policy makers.

I will ask for your permission to record the focus group, which will then be transcribed. The transcribed focus group will be stored on my computer, which has a password so only I can access it. I will not use any real names when I write about my research. I will make sure that people will not be able to tell who you are from my writings. All information you share with me will be treated confidentially. However, I may not be able to maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect of a child, dependent adult or elder, including, but not limited to physical, sexual, emotional, and financial abuse of neglect. Furthermore, it is not possible to guarantee that other participants will maintain confidentiality in focus groups as people may disclose what was discussed with persons outside the group. I will request that focus group participants respect each other's confidentiality by not speaking about what was discussed in the focus groups.

Once I have completed my research, I will write a thesis, which will be submitted to the University of Cape Town as my Ph.D. thesis. I will send my Ph.D. thesis to the Western Cape Health Department and publish the research in academic journals. I will present the research at conferences. Finally, I will invite all research participants to a colloquium (a big meeting) where I will present the research and discuss it with participants and other people interested in health committees.

Please fill free to ask any questions you have about the research, risks and benefits etc. either now or later. May I ask you some questions to make sure that I have explained everything well?

This research has been approved by the University of Cape Town's Health Faculty's Human Research Ethics Committee. Their job is to make sure that my research respects your rights. If you have any questions, complaints or concerns about this research, about your rights or welfare as a participant in the study, please contact them on the following phone number: 021 406 6338.

If you decide to participate in the study, I will ask you to sign a consent form, where you agree to participate. You do not have to make the decision immediately. If you need more time, let me know.

Regards,
Hanne Jensen Haricharan

Appendix E: Consent form, health committee member, focus group

Dear health committee member,

This consent form asks you for your permission to be part of my Ph.D. research on health committees. The consent form relates to being part of a focus group, which is expected to take between 1 and 1 ½ hour.

You have read the project information sheet and had a chance to ask questions about the research to enable you to decide on whether to be part of it or not.

I do not anticipate any risks associated with being part of the study. However, should you feel that the study creates any unforeseen problems or tensions (for instance in the health committee), support and/or mediation will be organized. Please contact me if the need arises.

I understand that taking part is voluntary and my signature indicate that I agree to be part of the project.

Name and signature of research participant.

Name *Date*

Signature

I agree to have the focus group recorded

☐ Yes

☐ No

Name and signature of researcher

Name *Date*

Signature