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EDITORIAL:

We are encouraged by our reviewers to publish what is effectively the first paper in the journal on spatial planning, its political economy and the struggle that revolves around it. Planning and the methodology utilized for it is, as is well known, unique in many ways in different countries. To be sure, spatial planning and land use diverge and co-evolves with societies and their governance systems. This would seem evident in Paul Hendler's piece in this volume. His focus is on South Africa and he attempts an understanding of the historical impact of ecological, political and economic factors on urban land usage. Hendler analyses historical data through a triangular matrix of capital accumulation, state reproduction and planning strategies and popular movements. He views capital accumulation as a process through which wealth produced by labour accrues both to owners of capital and managers in the form of unearned value. He suggests that this conceptualization of capital accumulation is particularly important in the current phase of global capitalism.

Nous sommes encouragés par nos réviseurs de publier ce qui est effectivement le premier article dans le journal sur l'aménagement du territoire, l'économie politique et la lutte qui tourne autour d'elle. La planification et la méthodologie utilisée car elle est, comme on le sait, unique à bien des égards dans les différents pays. Pour être sûr, l'aménagement du territoire et de l'utilisation des terres divergent et co-évolue avec les sociétés et leurs systèmes de gouvernance. Cela semble évident dans la pièce de Paul Hendler dans ce volume. Son accent est mis sur l'Afrique du Sud et il tente une compréhension de l'impact historique de facteurs écologiques, économiques et politiques sur l'utilisation des terres urbaines. Hendler analyse des données historiques à travers une matrice triangulaire de l'accumulation du capital, la reproduction de l'État et des stratégies de planification et de mouvements populaires. Il considère l'accumulation de capital comme un processus par lequel la richesse produite par le travail revient à la fois pour les propriétaires et les gestionnaires de capitaux sous la forme de la valeur non acquises. Il suggère que cette conceptualisation de l'accumulation du capital est particulièrement important dans la phase actuelle du capitalisme mondial.

Olajide Oloyede

Managing Editor/ Redactor En Cher

Capital accumulation, social reproduction and social struggle: rethinking the function of spatial planning and land use

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Abstract

This purpose of this paper is to understand the historical impact on urban land usage of ecological, economic and political factors in order to conceptualise strategic ideas for transforming urban land usage currently and in the future to enable social equity, promote the efficient use of resources and sustain the ecologies within which cities and towns are embedded. The paper analyses the historical data through a triangular matrix of capital accumulation, state reproduction and planning strategies and popular movements pressurizing to benefit from demanded land usages. Capital accumulation is viewed as a process through which wealth produced by labour accrues both to owners of capital and managers in the form of unearned value. This insight is particularly important in the current phase of global capitalism, in which financialisation is a dominant form of economic activity and impacts also on the way spaces are planned and used in urban areas for economic gain. Given the contradiction between an exponentially growing economy and finite resources, I take into account limits to growth and incorporate ecological economics' insights into classical political economy analyses.
Key words: *spatial planning, land use, capital accumulation, social reproduction, ecology*

Résumé

Ce but de cet article est de comprendre l'impact historique sur l'utilisation des terres urbaines de facteurs écologiques, économiques et politiques afin de conceptualiser des idées stratégiques pour transformer l'utilisation des terres urbaines actuellement et dans l'avenir pour permettre l'équité sociale, promouvoir l'utilisation efficace des ressources et soutenir les écologies dans lequel villes et villages sont intégrés. Le document analyse les données historiques à travers une matrice triangulaire de l'accumulation du capital, la reproduction de l'État et des stratégies de planification et de mouvements populaires de pressurisation de bénéficier des usages des terres réclamées. L'accumulation de capital est considérée comme un processus par lequel la richesse produite par le travail revient à la fois pour les propriétaires et les gestionnaires de capitaux sous la forme de la valeur non acquises. Cette idée est particulièrement important dans la phase actuelle du capitalisme mondial, dans lequel la financiarisation est une forme dominante de

l'activité économique et les impacts aussi sur la façon espaces sont prévus et utilisé dans les zones urbaines pour un gain économique. Compte tenu de la contradiction entre une économie en croissance exponentielle et de ressources limitées, je prends en compte les limites de la croissance et intégrer les perspectives de l'économie écologique en analyse l'économie politique
Mots clés: *aménagement du territoire , l'utilisation des terres , l'accumulation de capital , la reproduction sociale , l'écologie*

'Those who cannot remember the past are doomed to repeat it'.[1]

Introduction

The status of the spatial planning profession strongly influences the planning of land usage in our cities: the Spatial Planning and Land Use Management Act (SPLUMA) (RSA 16/2013) requires municipalities to develop Spatial Development Frameworks (SDFs) that define where and for what purpose land will be developed. Linked to the SDFs is 'spatial targeting', the idea that public investments in infrastructure in specific identified spaces will 'crowd in' household settlement, and private investment will follow, which ascribes to spatial planning the power to bring about access for citizens to services, facilities, employment and livelihood opportunities. Too often spatial planners assumes that bad outcomes are simply a reflection of problematic planning, but planning and planners do not stand above society and its network of conflicting political and economic interests. The options of how land is to be used are limited by factors external to planning: macro-economic trends that reinforce jobless growth as well as the need to maximise resource efficiency and conserve an increasingly threatened ecology (Department of Environmental Affairs, 2011: 10). Planning as a disciplined technique functions within a larger context where the influence of political and economic factors often undermines the best intentions of planners. This paper rethinks the current dominant technicist assumptions about the role of planning and its impact on space and land usage in order to lay a political economy basis for understanding historical spatial planning and urban land use strategies, and for proposing political and economic approaches to address spatial marginalisation and economic disempowerment of the majority of citizens in our cities.

Rethinking these phenomena requires understanding the political-economy of spatial planning and urban land usage, a different conceptual starting point to the current dominant neo-liberal way of seeing urban economic development, which confines itself to describing verifiable facts and eschews searching for theories to explain the underlying causes of phenomena.

1 Santayana (1998: 284)

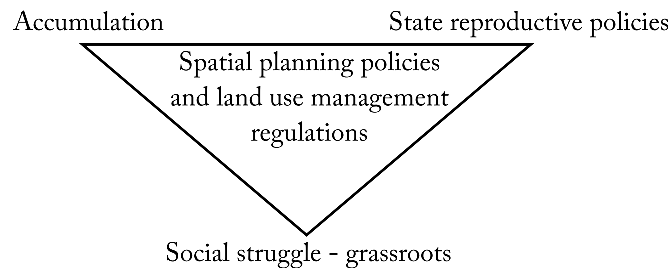
Spatial reproduction, capital accumulation and social struggle

To analyse economic and political structures as outcomes of the practices of historical agents, rather than as essential givens, requires specific concepts of what constitutes the economic and the political and their interrelationship.

'Facts' about the economy and the state are socially constructed through asymmetrical power relations between classes, genders, and ethnic and other social groups (Anthonissen, 2015: 5). These social relations of domination-subordination made settler colonialists dominant vis-a-vis indigenous people (Terreblanche, 2005: 6) and underlie the creation and reproduction of urban land use patterns.

Spatial planning and land usage forms are the outcomes past social struggles where grassroots actors and planning officials organised and formulated different narratives and exerted differential power. Knowing this history (Anthonissen, 2015: 5) and imagining a utopia, unencumbered by present-day restrictions (Turner, 1978: 11) can help understand how to reconstruct policies, and economic and spatial structures to enable employment in clean manufacturing located within sustainable socially equitable cities.

These struggles were framed by the interests underlying processes of *capital accumulation*[2], articulated with state *social reproduction* policies and practices[3]. The following is a graphic representation of the theoretical framework for understanding the historically changing spatial policies and land use management practices.



A key link between state policies and the economy is reproduction of labour power, i.e. the rejuvenation of the physical and mental abilities of people, in order for them to work (Althusser, 1970: 125-128). Reproduction of labour power for mining, manufacturing and agricultural capital happened through the statutory accommodation of workers

2 *Accumulation refers to a cycle of processes where money capital is invested in labour power and materials to produce new commodities, which are then exchanged for money – in this processes the owners of capital are driven to maximise profits and workers to maximise wages.*

3 *Social reproduction refers to processes like the provision of policing, education, housing, transportation as well as ideological discourses that give meaning to societies, where the state has performed – and continues to perform – historical functions, although social reproduction functions also extend beyond the state to maintain social relations of production.*

in defined spaces and under specific circumstances. Based on Hendler (1986; 2015a; 2015b) urban land use is analysed historically in terms of a periodisation of state policies, capital accumulation and social struggles. The purpose is to demonstrate the interdependence and interlinking of the state, capital accumulation and social struggles in the construction of urban land usages in South Africa (Hendler, 2010: 245-268; Poulantzas, 2000).

Financialisation and neo-liberalism

A key developmental challenge facing all our cities is the high levels of unemployment and the stark separation of living places (dormitories) from working places. The neo-liberal ideology regards the economy as a process where rational individuals compete for scarce resources, and which regulates itself and is therefore best left alone. However, to restructure economic processes and the spaces where they are practised, for job-intensive and green manufacturing, requires that we first understand how western capitalist economies were actually restructured since the late-1980s and 1990s, primarily through investment banking in a process that has been described as financialisation. Key characteristics were the expansion (and proliferation of types) of financial assets relative to real activity, absolute and relative expansion of speculative as opposed to or at the expense of real investment, a shift in the balance of productive to financial imperatives within the private sector, increasing income inequality arising out of financial rewards, consumer-led credit-based booms, penetration of finance into pensions, education, health, and provision of economic and social infrastructure, emergence of a neo-liberal culture of reliance upon markets and private capital and corresponding anti-statism (Ashman *et al*, 2011: 174-176).[4] One of the impacts of financialisation is deindustrialisation and therefore the loss of productive work opportunities. In contrast the political-economy framework enables us to see socio-political and macro-economic limitations (particularly the unsustainability of credit bubbles) to the progressive realisation of the 'right to the city'[5], rather than simply facilitating the privatisation and financialisation of the economy, which is often the economic usage to which re-planned and reconstructed urban land is put in these times.

4 *Indications are a $681 trillion global derivatives market, i.e. more than 10 times the value of underlying global GDP of $66 trillion (Hodgson-Brown, 2010: 192). In South Africa over 150% growth in the construction, finance and trade sectors and just 13% in manufacturing (2000 and 2008) (Bond, 2010: 21), illegal capital flight, exceeding 20% of GDP (2007) and the unbankabilty of 40% of the population (2011) (Fine, n.d.2: 3; 5). 'Jobless growth' also characterised the GDPs of Nelson Mandela Bay and Mangaung Metropolitan Municipalities (2010) (anecdotal evidence arising from consultancy work for these cities).*

5 *The 'right to the city' is an idea and slogan that was first proposed by Lefebvre (1968)*

Ecological economics

The global growth economic model is unsustainable (Swilling 2010: 11). Both neo-liberal ideology and classical political economy fail to consider the 'natural' limits to the supply of resource inputs to economic processes as well as the limited capacity of natural sinks to process the waste outputs from economic processes. Exponential economic and population growth places continuously increasing demand on limited planetary raw materials and resources; at the same time continuously expanding industrial waste is starting to overwhelm the finite ability of the earth's ecology to degrade noxious waste into benign components and to recycle these in the biosphere. Two stark examples of the limits to growth are the peaking of oil production and the inability of the earth's ecological systems to sufficiently sequester carbon from atmospheric carbon dioxide. The underlying depletion of oil supply is reflected in the trend rise in as well volatility of oil prices; oil price changes have a knock on effect on prices throughout the global economy because oil-derived products and by-products form part of all the materials in the production of commodities (Rubin, 2009). Global warming from green house gas emissions reflects the inability of ecosystems to sequester the carbon being spewed into the atmosphere. Globally, 40 per cent of energy use, 17 per cent of fresh water use, 25 per cent of wood harvested and 40 per cent of material use is attributed to the built environment (US Green Building Council, 2008), a direct link between urban land usage, carbon emissions and the ability of ecosystems to sequester carbon dioxide. To incorporate ecological and resource limits it is necessary to adopt the insights of ecological economics (Swilling, n.d. 28), the spatial implication of which is localisation of production and food supply, and densification and compactness of urban form due to the imperative to use resources more efficiently in the transition from non-renewable resources to renewable resources. For example, as oil starts becoming too expensive to sustain production and distribution of affordable food we will need to set aside more local spaces for organic urban agriculture. Similarly, as oil-based road motor transport becomes economically unsustainable, we will have to make the transition to electrified rail public transport and the overall land use management systems of our cities will have to be adjusted to include the requisite public transportation infrastructure.

In the history of urban land development in South Africa, agencies representing different class and ethnic interests contested ***where*** urban land should be developed and ***who*** (i.e. government, private industry or the people) should pay for these developments. The history of the planning of urban space and the management of the usage of land in these spaces has been periodised to reflect some of the key social reproduction interventions and their related economic accumulation rhythms.

The symbiotic and dynamic relationship between the economy (capital accumulation rhythms) and the spatial planning policies and land use regulations (functioning to reproduce social relations of production and social relations generally), develops historically through five periods: the period before 1913, the period between the 1913 Land Act and the commencement of apartheid, the period from 1948 to the 1976 Soweto Revolt, the period of apartheid reformism from 1976 to 1994 and finally the first 21 years of post-apartheid democracy. Within each period the planning of urban space and the designated uses ascribed to different parts of urban land, are analysed in terms of the logic of economic accumulation rhythms, associated planning and land use regulations as well as popular resistance to these, within a context of resource limits as well as the limits on natural sinks recycling industrial pollutants and sequestering carbon.

Historical interweaving of accumulation, reproduction strategies and struggles

Capital Accumulation/ Relations of Production	Social Reproduction through planning and land usage	Social Struggle against dominant land use regulations
Pre-1913: Creating the Basis for Segregation		
Agricultural land privatised, labour tenants pushed off this land resulting in a reserve army of labour migrating to towns. Basis for industrialisation created with establishment of the mining industry. Given relatively high capital costs of deep level mining profitability demanded that wages be constrained. Whites formed land-owning, capital-owning and managerial classes	Pass laws and segregated housing (in segregated locations) first introduced in the countryside (later including Cape Town and Port Elizabeth) and functioned to control the movement of labour for the agricultural and commercial sectors. Labour requirement of the mining industry met through compounds, which provided a total environment to control worker resistance, theft and the spread of disease (Callinicos, n.d; Davenport, 1971; Dedering, 2012; Home, 2000; Van Aswegen, 1970: 26–27).	The principal forms of resistance were through squatting – which was against the dominant regulations – and the strikes and other forms of resistance adopted by mine workers against the brutalising controls implemented in the compounds. White mine workers had craft unions that defended their interests
1913 to 1948 The 'Segregation Period'		
Close collaboration between agricultural and gold mining industries and the state (Terreblanche, 2005: 248-249). The Electricity Supply Commission (Eskom) was established in 1923 and the Iron and Steel Corporation (Iskor) in 1928, to produce relatively cheap, coal-fired electricity for mineral-based industries and an iron and steel smelting facility for exporting. There partnership between state and private capital, and a core set of activities around mining and energy, consolidated a "minerals-energy complex" (MEC) Fine (n.d.: 1).	Provisions to segregate the white and black working classes' urban living places, justified on the basis that blacks were temporary sojourners in 'white man's land' (Terreblanche, 2005: 255). Local authority structures set in place to fund – and control - housing developments for workers by local authorities (Calderwood, 1953). Key legislation enabled greater control over the reproduction of the labour power of the black workforce: municipalities could destroy and replan existing areas (Mabin and Smit, 1997: 200–202) as segregated townships, control land use, density, building size and position; the right of land tenure was withdrawn (Wilkinson, 1998: 217), and the right of accommodation in urban townships was linked to employment. Tension in these policies from manufacturing that required a settled urban workforce (Terreblanche, 2005: 279).	Resistance to segregation and controls led by SA Native National Congress (later the ANC), the Industrial and Commercial Workers Union (ICU), the Communist Party as the Confederation of Non-European Trade Unions (CNETU) during the 1930s. The African Mine Workers Union led a famous mine workers strike in 1946, which was suppressed when Smuts ordered the army to drive these workers to the coal face at bayonet point.

Capital Accumulation/ Relations of Production	Social Reproduction through planning and land usage	Social Struggle against dominant land use regulations
1948 to 1979 Apartheid and tightening of controls		
The MEC regime of accumulation continued under apartheid. Industrial decentralisation strategy – driven by infrastructure and incentives (Todes, 2013: 9) - created accumulation opportunities on homeland borders near to labour supply. Long boom in white property market (Chipkin, 2008: 104–129), decentralised commercial centres, (Beavon, 2000: 3), as financial institutions and insurance companies invested surpluses into shopping malls,1 while property developers diluted traditional role of architects in planning and initiating developments (Chipkin, 2008: 136). 1973 and 1979 global oil crises led to a drop in oil and fuel supply for Western economies, a significant rise in oil prices that fed an inflationary spiral and relative SA economic stagnation (Terreblanche, 2005: 337-340).	Planning urban space and managing land use in segregated townships to control movement of black labour, to build economy only on labour with permanent residential rights (Hindson, 1983, 1985; Posel, 1984, 1985), then a switch to an entirely migrant labour force (Posel, 1984: 6, 15, 23). Anti-squatting policies stopped autonomous community action (Wilkinson, 1981). The state, provided for transportation of workers according to industry needs, got industry to pay for reproduction of labour power costs through the Bantu Services Levy Act. Beer and liquor monopoly sales inside townships in white areas were run by local authorities – later central government administration boards – contributed significantly to meeting the cost of infrastructure and services. Later these funds redirected to newly constructed homeland townships. (Davenport and Hunt, 1975). Spatial planning (the Mentz Committee Reports, the Natural Resources Development Council and the 1975 National Physical Development Plan) (South Africa Union 1955: 4, quoted in Hendler, 1992: 41; Mabin and Smit, 1997: 205–206; Fair, 1975), public financial mechanisms and administrative controls, achieved land allocation and management objectives. Housing welfare subsidies provided for some – but not all (Parnell, 1987: 134) - poorer whites and home ownership subsidies for white suburbanites.	Stagflation was the macro-economic context within which increasing labour and community organisation resistance emerged against the imposition of apartheid spatial plans, labour controls and land use management regulations. Key tipping points were the 1973 Durban Strikes, the 1976 Soweto Uprising and the generalised labour and community movements that in the late-1970s emerged in the aftermath of the Soweto Uprising.

Capital Accumulation/ Relations of Production	Social Reproduction through planning and land usage	Social Struggle against dominant land use regulations
1979 to 1994 Revolt and Reform		
Financial capital grew to a larger portion of the GDP, concomittant with the deregulation of the economy. New, peripheral urban residential areas and industrial parks were developed. The 1982 Regional Industrial Decentralisation Programme incentivised labour-intensive industries in homeland areas and resulted in some 55 industrial development points in places such as Atlantis, Richards Bay, Isithebe, Rosslyn, Newcastle, Ladysmith, Butterworth, Dimbaza and Botshabelo. Between 1982 and 1987, some 147 000 jobs were created (compared to only 200 000 in the previous 21 years). Employment growth in these peripheral areas was much faster than in the cities, as labour-intensive jobs, particularly in the clothing industry, moved out (Todes, 2013: 10–11). This was also in part because companies were able to secure relatively cheap and disorganised (docile) labour at a time of 'stagflation' in the global economy.	Faced with intensified resistance and economic problems state and capital reformed apartheid reproduction mechanisms by: introducing a private housing market, reforming the labour market, removing restrictions (including trading restrictions), on urban residential rights of a minority of residents (in line with recommendations from Wiehahn2 and the Riekert Commissions3) and selectively upgrading township infrastructure. 1986: pass laws and township regulations abolished. Late-1970s: the state tried to win the 'hearts and minds' (ideological reproduction) of township residents by upgrading infrastructure of selected (mainly Witwatersrand) urban townships (SAIRR, 1983: 291; Hendler, 1986: 95), to return stability. Overall geopolitical reproduction strategy increased fragmentation and urban industrial sprawl, resulting in a separation of work and living opportunities, and long travel times and high transport costs for urban residents (i.e. contradictory reproduction of labour power impacts).	June 1976 uprising triggered opposition to stringent apartheid controls over land usage. Resistance undermined functioning of local government and municipal services. Central government declared a state of emergency. Army occupied most major townships. Community organisations assumed functions of local government. Civic associations conceptualise (and sometimes implemented) institutional structures, like community development trusts and community land trusts (e.g. in Tamboville, Wattville and Alexander), housing associations and housing cooperatives (e.g. Seven Buildings Project in Hillbrow).4

Capital Accumulation/ Relations of Production	Social Reproduction through planning and land usage	Social Struggle against dominant land use regulations
1994 to 2015 The new dispensation		
High unemployment and inequality have persisted. (Fine, n.d.) – MEC corporates not committed to economic and social restructuring to expand local economy, rather promoting non-value-adding black economic empowerment through financialisation and investing heavily in offshore financial assets.5 SA economy constrained by integration of global trade and financial flows, huge imbalances between the US, China and Japan, and the 2007/2008 global financial crisis (Mohammed, 2011: 15-16), triggered by oil supply depletion. Volatility likely to continue until we wean our economies off oil and other non-renewable fossil fuels (Rubin, 2009: 207-242). Current financial bubble and oil depletion will reproduce economic volatility and stagnation, making private car transport as well as food more expensive (both dependent on oil and petrochemical intermediate-product inputs). There is a need for transportation and food alternatives: in the Johannesburg 42 per cent of households can be classified as 'food insecure' (Camaren and Swilling, 2011: 21; Frayne et al., 2009: 1; DGE, 2010: 12) while the road motorised transport sector consumes 78 per cent of liquid fuels in the country (Association for the Study of Peak Oil, 2013: 78).	Apartheid spatial planning and land use management social reproduction regulations removed, to enable effective and efficient urban land markets.6 New regulations and public funding interventions: social grants to cushion the harsh effects of persistent unemployment (and preserve social peace); free housing on cheap (peripheral) land and some further rights for informal settlement dwellers to limit the exposure to homelessness – these functions reproduce the reserve army of labour, given the extent of unemployment. Universal access to free elementary and secondary education and the public health care system perform reproduction of labour power functions unevenly – curricula are often misaligned with industry needs, the schooling system often lacks the discipline to instill into someone to become a productive worker and the debacle around the provision of anti-retrovirals for HIV-positive people (under President Mbeki) resulted in the deaths of hundreds of thousands of people.	Socio-economic marginalisation drove ever-increasing occurrences of social protests across the country between 2004 and 2008 when there were 34 610 incidents (mainly in Gauteng and KwaZuluNatal, followed by the Eastern Cape) (Alexander, 2010: 26, referring to South African Police Services' Incident Registration Information System and Vally, 2009). A further 1 027 protest actions took place between January 2009 and June 2010 (Hirsh, 2010: 4). In early 2014 there was an average of 6 protests per working day in Gauteng (Eliseev, 2014). Services provided since 1994 have been geographically uneven, poorly managed and maintained while councilors have capitalised on accumulation through privatisation, with ANC power struggles and police violence being contributory factors (Alexander, 2010: 31-38).. Protests are both spontaneous and organised. The Informal Settlements Network (ISN) and Abahlali baseMjondolo, are two independent shack dwellers' movements (Hendler, 2014; Birkinshaw, 2008). The Anti Privatisation Forum (APF), the Landless Peoples Movement (LPM) and the Soweto Electricity Crisis Committee (SECC) are activist, campaigning against privatisation of municipal utilities (Ngwane and Vilakazi, n.d.: 15). Resistance to environmental degradation and exploitation of fossil fuel resources emerged through the Treasure Karoo Action Group and the South Durban Community Environmental Alliance (SDCEA) (South Durban Community Environmental Alliance, 2011: 120). The xenophobic (or afrophobic) attacks of 2008 are viewed as displaced anger at social exclusion and marginalisation (Glaser, 2008: 53-64; Gelb, 2008: 79-92; Silverman and Zack, 2008: 147-160), within an exclusivist conception of citizenship founded on indigeneity and a conception of the state as technical expert and manager of development (as opposed to peoples-driven development) (Neocosmos, 2006: 5-10).

Within the above historical framework we can now locate specific state spatial reproduction functions in the form of laws and regulations relating to urban land rights, land ownership and environmental conservation. The following section narrates the impact of these factors on class/ ethnic segregation, the range of housing types built, the development and underdevelopment of different areas, population densities, and sprawling versus compact infrastructure for development. In each historical period the comparative per capita personal incomes for the different ethnic groups are also given to illustrate the levels if income disparities that mirrored the broader social power imbalances and spatial morphologies.

Historical Impact of Urban land Usage on Space and Society

Reproduction Factor	Ethnic/class integration/ segregation,	Range of housing types,	Developed/underdeveloped areas	Low versus high population densities,	Sprawling versus compact infrastructure	Per capita personal Incomes by racial group (in constant 1995 Rands)[7]
Pre-1913: Creating the basis for segregation						
Urban land Rights:	Segregated town locations and employer accommodation first introduced and squatting prohibited (but happened anyhow).	Mainly self-erected informal structures in segregated locations and barracks in the mining compounds, while formal brick and mortar accommodation and mansions were erected for the noveau-riche.	The land and property owning classes emerged in new residential towns and cities while workers and people of colour generally were accommodated separately in less developed areas	Population densities were generally much lower in the areas of the land owning and managerial classes, than for the working classes and people of colour	There was little if any infrastructure in segregated living areas for workers and people of colour, who were displaced from the centre of towns, creating the precedent for future sprawling mass dormitory townships	
Land Ownership:	Emerging white entrepreneurs were the main land owners (Butt, 1984; Chipkin, 2008). Small white farmers lost their land through recessions and were forced into wage labour on the mines, and rented accommodation.	White workers did not live under the brutalising controls that workers of colour faced, mainly in the compounds of the mines.	Working class areas were generally underdeveloped in comparison with the residential areas of the nouveau riche			
Environmental Impact:	The living environments of the nouveau riche were generally better serviced than areas for the working classes and people of colour, who sometimes endured severely degraded living environments and were exposed to health hazards.	Workers and people of colour housed themselves in informal structures in segregated areas while mine employees were housed in compounds. In the white suburban areas mine magnates and the nouveau riche lived in large spacious homes and mansions.	Being relatively expensive, the deep-level mining industry was always looking to cut costs. As a result, the quality of life in the emerging working class living places was neglected, and toxic waste output and acid mine drainage added pollutants to the local ecosystems.			

Reproduction Factor	Ethnic/class integration/ segregation,	Range of housing types,	Developed/underdeveloped areas	Low versus high population densities,	Sprawling versus compact infrastructure	Per capita personal Incomes by racial group (in constant 1995 Rands)[7]
1913-1948 – the 'segregation period'						
Urban land Rights:	Statutory and funding requirements for future segregation practices were completed, and the process of segregating the white working class from the broader proletariat commenced.	Many black workers housed themselves (often in informal structures) within segregated 'locations' close to where they worked (Hendler, 1986: 67).	There emerged a distinction between the 'civilised and upgraded (white) areas and the underdeveloped 'native' areas.	The low density of suburban housing persisted in this period, while densities in mixed inner city neighbourhoods and peripheral segregated areas remained higher largely due to smaller plots and sometimes overcrowded informal structures.	Provision was made for clearing slums and installing infrastructure in new segregated townships – peripheralisation implied a form of infrastructure that encouraged relatively low density sprawling dormitory townships,	1917: Whites: R9 369 Coloureds: R2 061 Asians: R2 075 Africans: R849 1936: Whites: R13 773 Coloureds: R2 151 Asians: R3 185 Africans: R1 048 1946: Whites: R 18 820 Coloureds: R3 068 Asians: R 4 238 Africans: R1 671
Land Ownership and Development:	Ownership of land by people of colour severely restricted or (in the case of Africans) continuously undermined in terms of the principle of temporary sojournership.	Local government rental subsidies were provided for white workers (Parnell, 1987: preface; 129-137). Some capital was also funneled for formal housing for people regarded as 'Indian' and 'coloured'.	White areas were developed philanthropically as part of a crusade to 'save white workers for civilisation' (Garden Cities, 1972: 11-12; 17; Citizens Housing League, 1979; Die Stedelike Behuisingsbond, 1970). This stood in stark contrast with areas where people of colour lived.			
Environmental Impact:	White living/commercial areas, well served with water, sanitation and electrical reticulation while black areas relied on coal/wood stoves for cooking and warmth. Poor sanitation at times posed a general public health hazard.	Differential housing types manifested in white areas. Some formal housing was built in segregated townships, while most accommodation remained either informal or mining compounds. Limited construction of some formal housing for poorer sections of the white working classes.	More nature conservation areas/game parks declared for whites. 'Homelands' and 'black' urban centres suffered severe environmental degradation (Sowman et al., 1995: 3). One consequence was the influenza epidemic in the 1920s, claiming the lives of 500 000 Africans (Morris 1981: 15–16).			

Reproduction Factor	Ethnic/class integration/ segregation,	Range of housing types,	Developed/underdeveloped areas	Low versus high population densities,	Sprawling versus compact infrastructure	Per capita personal Incomes by racial group (in constant 1995 Rands)[7]
1948-1979 Apartheid and tightening of controls						
Urban land Rights:	Stringent application of urban segregation through group areas, cleaning up black spots, etc. African residents categorised as migrants or with urban residential rights.	Rental of matchbox houses, main urban tenure for Africans. 30 year leasehold, 1950s to 1968, reintroduced in 1975; 1968 to 1975 'right to occupy' family housing restricted to homeland conurbations (Morris, 1981: 49, quoted in Hendler, 1986: 81; SAIRR, 1977: 187, quoted in Hendler 1986: 87).	Townships, initially constructed on new infrastructure, deteriorated from the late 1960s as infrastructure left unmaintained. By contrast suburbanisation in white areas on basis of modern electrical, sanitation and water infrastructure.	Proliferation of low density urban forms, including segregated black (urban and homeland) living places and suburbanisation, decentralised shopping centres in areas prescribed for whites.	Suburbanisation as well as decentralisation meant a form of infrastructure that facilitated growing urban sprawl.	1960: Whites: R22 389 Coloureds: R3 568 Asians: R3 828 Africans: R1 815 1970: Whites: R32 799 Coloureds: R5 684 Asians: R6 630 Africans: R2 246
Land Ownership and Development:	Ownership rights severely restricted for Africans in urban areas but reintroduced for 'urban insiders' during the mid-1970s.	By 1968: five tenancies in public housing: site and building permits; occupation certificates/residential permits (from municipality); lodger's permits (renting from households); and, hostel permits (renting hostel beds). In homeland conurbations: a deed of grant from the traditional authorities (Hendler, 1993: 396–397).	Privately owned land could be – and often was – expropriated for segregated township development. The government micro-managed the movement and accommodation of the urban workforce (and redirected development funding) on state-owned land in both white areas and homelands.			
Environmental Impact:	Significant atmospheric pollution of African townships – they lacked electricity. Expert/elitist environmental planning started emerging in the 1970s (Sowman et al., 1995: 50–55).	Segregated townships constructed in a grid of rows of matchbox houses, housing Africans moved from informal settlements and decaying inner city neighbourhoods. Initially resembled cleaner living environments but deteriorate during the 1970s when the emphasis shifted to homeland towns.	Expanding white property market environmentally clean, built on infrastructure and cheap Eskom electricity as well as sanitary and water reticulation. However toxicity from mines was noticed already in the 1960s.[8]			

Reproduction Factor	Ethnic/class integration/ segregation,	Range of housing types,	Developed/underdeveloped areas	Low versus high population densities,	Sprawling versus compact infrastructure	Per capita personal Incomes by racial group (in constant 1995 Rands)[7]
1979-1994 revolt and reform						
Urban land Rights:	Control over movement eased for Africans with urban rights but tightened up for migrant (contract) workers	Affordable private developer housing for urban insiders. Sold state units, some of which upgraded, entered housing market. Informal structures grew in the backyards and in free-standing settlements.	Distinction between developed white and underdeveloped township areas persisted, although certain townships were upgraded in response to social uprisings.	There was an increase in informal settlements, which translated into higher population densities than in the suburbs but still relatively low densities by other third world country standards.	The increasing extent of informal settlement contributed to an already sprawling urban residential land environment	1980: Whites: R34 655 Coloureds: R6 623 Asians: R8 821 Africans: R2 931
Land Ownership and Development:	Segregation persisted after abolition of pass laws, Group Areas and other racially-based land statutes. Affordability became the criterion of access. Increase in squatting (informal settlements) closer to urban centres.	Homeownership: 1978: 30-year upgraded to 99-year lease, with building societies loans; 1984: lease title transfer perpetual, convertible to freehold, registrable in Deeds office (SA/TVBC[9] citizens); selling of 350 000 state units (Hendler, 1986: 95–96; Hendler, 1993: 78; SAIRR, 1984: 270); and, 1987: developers acquire stands in townships (Urban Foundation, 1987, quoted in Hendler, 1993: 393–394)	With the development of a housing market segregated housing classes soon appeared within existing underdeveloped townships with a smaller elite section comprising the new homeownership class.			
Environmental Impact:	(1987): per capita carbon emissions (whites): 9 tons compared to US: 5 tons, globally: 1 ton. Respiratory diseases townships from coal stoves (Durning, 1990: 8–13). 1980s: environmental impact assessments (EIAs) on the agenda (Sowman et al., 1995).	The differentiation of housing types (and classes) in still segregated townships, combined with the upgrading of certain townships, contributed to an improved environment through fully reticulated serviced housing, in some of these areas	Environmental impact regulations (requiring environmental impact assessments at all stages of the planning of development projects) were incorporated into the spatial planning regime of Integrated Environmental Management (IEM) (Sowman et al., 1995: 50–55).			

Reproduction Factor	Ethnic/class integration/ segregation,	Range of housing types,	Developed/underdeveloped areas	Low versus high population densities,	Sprawling versus compact infrastructure	Per capita personal Incomes by racial group (in constant 1995 Rands)[7]
1994-2015 The new dispensation						
Urban land Rights:	Urban land rights universally applicable, apartheid restrictions dropped. Economic (employment and affordability) obstacles hinder majority's 'right' to the city, since 2004 prompting protests about inequalities and marginalisation.	Policy objective: centrally located housing, mixed residential/retail/ commercial development, and a secondary market. However municipalities sold central land, invested proceeds in peripheral RDP housing. Existing property market values expanded while peripherally only basic formal shelter was developed.	Apart from some of the larger and better-known townships – like Soweto – and new areas – like Cornubia (KwaZulu Natal) and Cosmo City (Gauteng) – the old pattern of developed colonial centres and peripheral underdeveloped areas, has persisted.	Government's stated intention has been to facilitate integration and densification of work, living and recreational spaces (i.e. the 1994 Housing White Paper, the 2003 National Spatial Development Perspective [NSDP] and the 2004 Breaking New Ground: A Comprehensive Policy on Sustainable Human Settlement [BNG]), statutory requirements for municipal integrated development plans (IDPs), spatial development frameworks and public-private partnerships (National Department of Human Settlements, n.d.: 2). Densities however remain relatively low and sprawl has persisted		1995: Whites: R34 689 Coloureds: R6 931 Asians: R16 793 Africans: R4 678 Household income distribution (2011): 15,4 % earn more than R15 000 monthly 11,6% earn between R7 501 and R15 000 15,9% earn between R3 501 and R7 500 57,1% earn between R0 and R3 500
Land Ownership and Development:	Minority from townships moved into gated communities, new township suburbs (e.g. Soweto), new mixed income projects (e.g. Cosmo City in Gauteng and Cornubia in Durban), and upgraded/refurbished buildings for rental (Johannesburg and Pretoria CBDs). Residents unable to afford homeownership/rent excluded.	Suburban housing - 1997 to 2008: prices rose by 389 per cent, compared with Ireland (193 per cent) and the United States (66 per cent) (Bond, 2010: 18), focus on compaction contributing through creating scarcity.15 per cent of households (above R15,000 income) afford established housing markets (Appendix, household income profiles). The 'gap' ownership market (R300,000 and R500,000) despite new financial products. Many informal structures erected (NUSP, n.d.).	High land prices confined BNG housing to peripheral townships. 57 per cent of households are excluded from 'right' to the city, as they earn less than R3501 per month (including social grants) and are on long waiting lists for government housing (Appendix, household income profiles).			
Environmental Impact:	The large-scale provision of electricity has helped to curb the worst atmospheric pollution in previously segregated townships.	Strong biodiversity conservation measures (SANBI, 2014: 17–60), the National Environmental Management Act (NEMA) (No. 107 of 1998) covers pollution control, waste management, environmental authorisations and natural and cultural resources use and conservation. Nevertheless, 57 per cent of river ecosystems and 65 per cent of wetland ecosystems classified as threatened (Driver et al., 2003: 5-6).	Specifications of bioregional plans sometimes not incorporated into municipal IDPs, or sectoral strategies.10 Examples: in Polokwane,11 acid mine drainage pollution (affecting West Rand informal settlement communities12), air pollution (oil refineries and burning biomass in Durban South) (South Durban CEA, 2011), and the exploration for fracking in the Karoo.13			

Conclusion: Possibilities and Limits for Municipal Interventions

From the history of planning and land use in South Africa, a number of lessons can be drawn about the potential for, and limitations on, municipalities effecting changes.

Simply removing segregationist land use regulations does not create integrated and sustainable living, working and recreational areas. Large parts of the bigger townships like Soweto may have transformed and suburbanised, while some black people have moved into modern white suburbia. However, much more is needed. An important aspect of urban land use is for urban spaces to be identified symbolically, whether as 'world class cities', 'African cities' or 'working class cities'.

Municipal land use strategies and practices tend to favour private business interests, often at the expense of redistribution. Privatisation of municipal services, the lax regulation of fossil fuel polluting emissions (e.g. in Durban South) and the World Cup stadiums opened new opportunities for private accumulation by local and global interests. In addition, property rates-based funding incentivises escalating property values (benefitting real estate players, particularly banks), encouraging municipalities to sell their non-core land for the highest price rather than to embrace a role as property developer of prime land to create and reproduce quality of life for the working poor and unemployed.

The municipal funding model inhibits a transition to residential solar energy through feed-in tariffs. However, Eskom's current crisis might be a 'burning platform'[6] that could prompt a change to renewables. At a March 2015 Urban Conference hosted by the SA Cities Network, the Mayor of Tshwane expressed the need for a new municipal funding model that would liberate municipalities from rates-based and trading services funding. However, this will require either transfer payments from national government or a sharing of the taxation of companies operating within municipal jurisdictions.

By the mid-Century there will be unsustainable demand for key material resources as well as rising negative environmental impacts of expanding waste outputs unless there is 'decoupling of this economic growth from escalating resource use' (Hodson, *et al* (2012: 790). Decoupling means reducing the rate at which primary resources are used per unit of economic output and/or increase economic activity while decreasing negative environmental impacts like pollution, CO2 emissions or the destruction of biodiversity (Hodson, *et al*, 2012: 798). Compact and densified development in a city environment is a precondition for the efficient usage of resources, which also provides an opportunity for decoupling economic growth from escalating resource use (Camaren and Swilling, 2011). By circumscribing the roll out of infrastructure, compaction and densification create a platform for the efficient use (and re-use) of all resources (e.g. water, energy, forests, wetlands, etc) and thereby extend the time frame of the functioning ecological platform of urban-based societies and economies. Decoupling might open the door for a more fundamental restructuring of the urban form but this is not guaranteed.

6 *Edgar Schein's burning platform theory is that for people to make a leap from today's platform to the relative unknown, it must be more uncomfortable for them to stay on today's platform than the perceived anxiety created by the change to tomorrow's desired future (Alan, 2010)*

The way in which municipalities spatially plan and implement services and land usage is likely to come under more pressure from spontaneous protests, creating pressure for change. In an increasingly volatile environment, municipalities will have an interest in stability. They might resort to repression (e.g. eviction of informal traders and squatters, cutting off water and electricity supplies to defaulters, etc.) but this will secure stability only in the short term, given the underlying macro-economic drivers of protest activity. In the medium to long term, negotiations with representative and organised community groups could lead to agreements with protesting communities and a greater likelihood of stability. The SPLUMA contains the statutory framework for agreements with communities aimed at enhancing their right to the city. Embedded in this framework are principles of spatial justice and spatial sustainability, which justify strategies for improving the working class's access to cities and quality of life. These above principles, together with the principles of financial sustainability, administrative sustainability, efficiency, transparency and public interest, form an overall guide for municipal governance, spatial plans and land-use management that support the development of working-class urban spaces for living, working and recreation. Within the overall framework of the principles enunciated by SPLUMA, the Constitution and the Municipal Finance Management Act, municipalities need to formulate processes and procedures for acquiring, holding, developing and releasing land.[7]

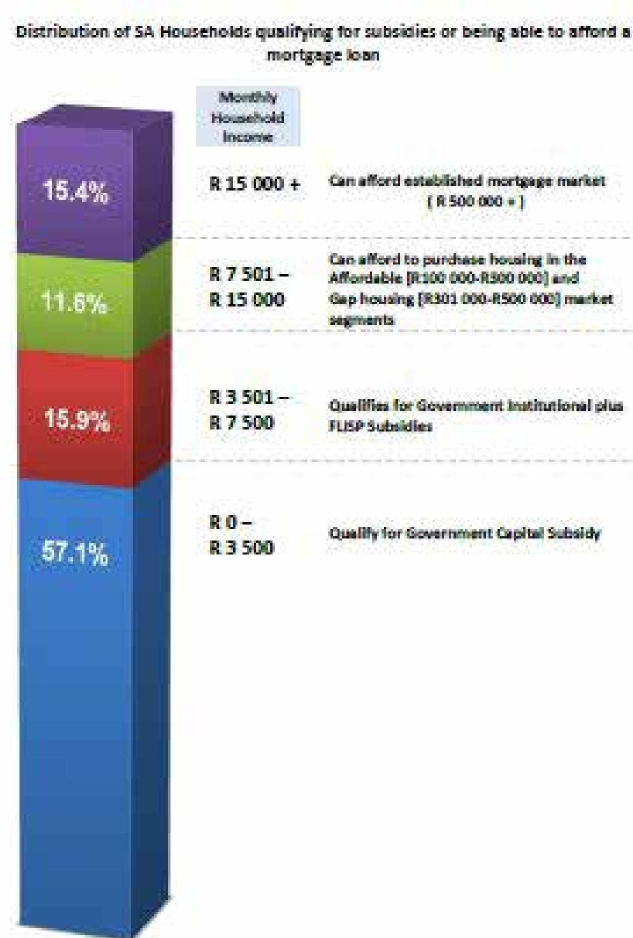
Whether negotiations between municipalities and community representatives take place and develop into a different set of spatial planning and land use practices will depend on the role of progressive senior municipal officials, such the Stellenbosch Municipal Manager who facilitated the memorandum of understanding with the Informal Settlements Network (ISN) for upgrading the Langrug informal settlement (outside Franschoek). The Langrug organisers also developed strong relationships with municipal officials responsible for providing and maintaining services to human settlements and with the planning departments of academic institutions, which helped envision – and plan – a different, connected Langrug in the future.[8]

7 *These strategies and processes were developed by the author and a colleague as part of a professional service for the Housing Development Agency (HDA) during 2012.*

8 *Hendler P. 2014. 'Using hindsight to orrganise better – grassroots service solutions, Cape Times, 30 January.*

Appendix

South African households that qualify for housing subsidies or can afford a mortgage loan



SOURCE: StatsSA, Census 2011

References

Alan, Craig 2010 Organisational Excellence, available on line at https://craigalan.wordpress.com/2010/07/12/creative-tension-burning-platform-goals-and-change/

Alexander, P 2010 Rebellion of the poor: South Africa's service delivery protests – a preliminary analysis, Review of African Political Economy, 37, 123, 25-40, available on-line at http://dx.doi.org/10.1080/03056241003637870

Althusser, L 1970 Ideology and Ideological State Apparatus, in Althusser, *L Lenin and Philodophy and Other Essays*, Monthly Review Press, London and New York, 127-168

Anthonissen, C 2015 Multilingual Spaces as Contact Zones: 'Critical' things we need to know about Critical Linguistics, Inaugural Lecture, Stellenbosch University, 16 April

Ashman, S Fine, B and Newman, S 2011 The crisis in South Africa: Neoliberalism, Financialization and Uneven and Combined Development, Socialist Register, 47, 174-195, available on line at http://socialistregister.com/index.php/srv/article/view/14326#.VX1-5ksZ0pE

Association for the Study of Peak Oil, 2013 Energy and Transport Status Quo: Demand and Vulnerabilities (unpublished), a report submitted to the National Department of Transport

Beavon K 2000 Northern Johannesburg: part of the 'rainbow' or neo-apartheid city in the making? Mots Pluriels, available on-line at: http://www.arts.uwa.edu.au/MotsPluriels/MP1300kb.html

Bond, P 2010 South Africa's Bubble Meets Boiling Urban Social Protest, Monthly Review, June

Butt PE. 1984 The Growth and Development of the Organised Building Industry in the Western Cape with an Investigation into the Forces that have Shaped It, Dissertation submitted to the Faculty of Architecture and Allied Disciplines of the University of Natal, Durban in complete fulfilment of the requirements for the Degree of Master of Science (Building Management), Cape Town, January

Calderwood, D 1953 Native Housing in South Africa, a dissertation submitted to the University of the Witwatersrand for the degree of Doctor of Philosophy

Callinicos L. the Compound System in Callinicos L *Gold and Workers*, available on line at: http://v1.sahistory.org.za/pages/library-resources/onlinebooks/Luli/Gold-and-workers/part%202/unit11.htm

Camaren, P and Swilling, M 2011 Sustainable, Low-Carbon Cities in the 21st Century – Making it Happen! Paper for the Summit for the Urban Environmental Accords, October 11-13, Gwangju, South Korea Commissioned by UNEP

Chipkin CM. 2008 Johannesburg Transition – Architecture and Society from 1950, STE Publishers, Johannesburg, 49-75.

Citizens Housing League, 1979 1929 – 1979: 50 Years Service, the Citizens Housing League, Cape Town

Davenport R, and Hunt K 1975 *The Right to the Land – Documents on South African History,* David Phillip, Cape Town

Dedering T. 2012 Compounds, camps, colonialism, Journal of Namibian Studies, 12 (29-46)

DGE, 2010 A Strategy for a Developmental Green Economy in Gauteng, Report Prepared for the Gauteng Province Department of Economic Development, Gauteng Provincial Government

Department of Environmental Affairs. 2011 The National Strategy for Sustainable Development and Action Plan (NSSD1)

Die Stedelike Behuisingsbond, 1969 1929 toot 1969 – 40 Jaar Diens

Driver, A Cowling, R and Maze, K 2003 Planning for Living Landscapes Perspectives and Lessons from South Africa, Cape Town, available on line at available at www.botanicalsociety.org.za/ccu or www.biodiversityscience.org

Durning, A 1990 Apartheid's Environmental Toll, Worldwatch Institute Paper, May

Eliseev, A 2014 Analysis: Bonfires of discontent, in horrifying numbers, in *Daily Maverick*, 5 February, available on line at http://www.dailymaverick.co.za/article/2014-02-05-analysis-bonfires-of-discontent-in-horrifying-numbers/#.VUYrhEsZ0pE

Fair, D 1975 The National Physical Development Plan (NPDP): A Summary And A Review, South African Geographical Journal, 57, 2, 126-134, available online at http://www.tandfonline.com/loi/rsag20

Fine, B (n.d2.) Assessing the New Growth Path: Framework for Change?, available on line at http://eprints.soas.ac.uk/13053/

Frayne, B Battersby-Lennard, J Fincham, R. and Haysom, G 2009 Urban Food Security in South Africa: Case Study of Cape Town, Msunduzi & Johannesburg

Garden Cities, 1972 1922 – 1972: Fifty Years of Housing – The Story of Garden Cities, Garden Cities, Pinelands, Cape Town

Gelb, S 2008 Behind Xenophobia in South Africa – Poverty or Inequality?, in Hassim, S Tawana, K and Worby, E (ed) *Go Home or Die Here*, Wits University Press, Johannesburg

Glaser, D 2008 Disconnections: Elite and Popular 'Common Sense' on Matter of 'Foreigners', in Hassim, S Tawana, K and Worby, E (ed) *Go Home or Die Here*, Wits University Press, Johannesburg

Groundwork, 2014 Shell: Don't Frack the Karoo, Groundwork, Southern Cape Land Committee and Millieudienste (Netherlands), available on line at https://milieudefensie.nl/publicaties/rapporten/shell-dont-frack-the-karoo

Hendler, P. 1986 Capital Accumulation, the State and the Housing Question: The Private Allocation of Residences in African Townships on the Witwatersrand 1980 to 1985, A thesis submitted to the University of the Witwatersrand in fulfillment of the requirements for the degree of Master of Arts in the Faculty of Arts, University of the Witwatersrand, Johannesburg

Hendler P and Spiropolous J 1991 Development Institutions in the context of Planact's Physical Implementation projects, Planact, November (unpublished)

Hendler P 1992 Living in Apartheid's Shadow, Urban Forum, 3(2), 39-80 June

Hendler, P 1993 Privatised Housing Delivery, Housing Markets and Housing Policy: Residential Land Development for Africans in the Pretoria/Witwatersrand/Vereeniging Region between 1975 and 1991, a thesis submitted to the Faculty of Arts, University of the Witwatersrand, for the Degree of Doctor of Philosophy

Hendler P 2010 Governance, Housing and Sustainable Neighbourhoods, in Swilling M *Sustaining Cape Town – Imagining a Livable City*, Sustainability Institute and Sun Press, Stellenbosch

Hendler P. 2013 Personal Communication with Professor Francois Viruly, Property Specialist, March

Hendler, P 2014 Using Hindsight to Organise Better – Grassroots Service Solutions, in Cape Times 30 January

Hendler, P 2015a The Right to the City: The Planning and 'Unplanning' of Urban Space since 1913, in Cousins B and Walker C (eds) *Land Divided, Land Restored – Land Reform in South Africa for the 21st Century*, Jacana, Auckland Park, 85-103

Hendler, P 2015b Urban Land History - Dynamics which still influence the present, a working paper for the SA Cities Network Working Paper Series on Urban Land

Hindson, D 1983 The Pass System and the Formation of an Urban African Proletariat ion South Africa: A Critique of the Cheap Labour Power Thesis, a dissertation submitted to the University of Sussex for the Degree of Doctor of Philosophy

Hindson, D 1985 The Pass System and Differentiated Labour Power, paper presented to the Association for Sociology in Southern Africa (ASSA) conference, University of Cape Town, July

Hirsh, J 2010 Community Protests in South Africa: Trends, Analysis and Explanations, the Local Government Working Paper Series, Community Law Centre, University of the Western Cape, available on line at http://www.communitylawcentre.org.za/Projects/Local-Government

Hodson, M Marvin, S Robinson, B and Swilling M 2012 Reshaping Urban Infrastructure: Material Flow Analysis and Transitions Analysis in an Urban Context, Journal of Industrial Ecology, Vol 16, 6, Yale University, 2012, available on line at www.wileyonlinelibrary.com/journal/jie

Hodgson Brown, E 2010 The Web of Debt – The Shocking `Truth about our Money System and How We Can Break Free, Third Millenium Press, Baton Rouge, Louisiana

Lefebvre H. 1968. *Le Droit à la ville* Paris
Mabin, A and Smit, D 1997 'Reconstructing South African Cities? The making of urban planning 1900 to 2000', Planning Perspectives, 12, 2, 193-223
Mohammed, S 2011 Negative Trends in the South African Economy: How should these be overcome?, in Mbeki M (ed) *Advocates for Change – How to Overcome Africa's Challenges*, Picador Africa, Johannesburg
Morris, P 1981 A History of Black Housing in South Africa, South African Foundation
National Department of Human Settlements, n.d. Sustainable Human Settlement Planning – A Resource Book on Housing Chapters
National Upgrading Support Programme (NUSP) (n.d.) available on line at http://www.upgradingsupport.org/content/page/history
Neocosmos, M 2006 From 'Foreign Natives' to 'Native Foreigners' – Explaining Xenophobia in Post-Apartheid South Africa – Citizenship and Nationalism, Identity and Politics, Codesria Monograph Series, Dakar, Senegal, available on line at www.codesria.org/IMG/pdf/**neocosmos**-3.pdf
Ngwane, T and Vilakazi, N n.d. The Anti-Privatisation Forum and Campaign against Xenophobia, Centre for Sociological Research, University of Johannesburg
Noseweek, 2013 "2013 – Here comes the poison", No 162, April, 10-13
Noseweek, 2015 "A plague on frogs – an the people of Polokwane – Nature buffs unearth dark secrets of dodgy property deals", No 187, May, 20-23
Parnell, S 1987 Council Housing Provision for Whites in Johannesburg: 1920 – 1955, A Dissertation submitted to the Faculty of Arts, University of the Witwatersrand, Johannesburg, for the Degree of Master of Arts
Posel, D 1984 Providing for the Legitimate Labour Requirements of Employers, paper presented to the African Studies Seminar, African Studies Institute, University of the Witwatersrand, Johannesburg
Posel, D 1985 Interests, Conflict and Power: The Relationship between the State and business in South Africa during the 1950s, paper presented to the Association for Sociology in Southern Africa (ASSA) conference, University of Cape Town, July
Poulantzas N 2000 State, Power, Socialism, Verso Classic, London
RSA 16/2013, Republic of South Africa, Spatial Planning and Land Use Management Act, no 16 of 2013
Rubin J 2009 Why your world is about to get a whole lot smaller – oil and the end of globalisation, Random House, New York
SANBI (South African National Biodiversity Institute), 2014. Biodiversity Mainstreaming Toolbox for land-use planning and development in Gauteng. Compiled by ICLEI – Local Governments for Sustainability
SAIRR, 1977 South African Institute of Race Relations – A Survey of Race Relations 1976, SAIRR, Johannesburg

SAIRR, 1983 South African Institute of Race Relations – Survey of Race Relations 1983, SAIRR, Johannesburg
SAIRR, 1984 South African Institute of Race Relations – Survey of Race Relations 1984, SAIRR, Johannesburg
Santayana, G 1998 Reason in Common Sense, *Volume 1 of The Life of Reason*, New York
Segar S 2013 "Wonderwoman – Gauteng's Last Hope", in Noseweek 162, April, 14-16
Silverman, M and Zack, T 2008 Housing Delivery, the Urban Crisis and Xenophobia, in Hassim, S Tawana, K and Worby, E (ed) *Go Home or Die Here*, Wits University Press, Johannesburg
South Africa Union 1955 The Report of the Committee appointed to Investigate the Question of Residential Areas for Natives in the East Rand Area (the Mentz Report), Part Four, (in Afrikaans), Johannesburg Municipal Library
South Durban Community Environmental Alliance, 2011 Feeling the Heat in Durban, in Bond, P (ed) *Durban's Climate Gamble – Trading Carbon Betting the Earth*, 117-140, Unisa Press, University of South Africa
Sowman, M Fuggle, R and Preston, G 1995 A Review of the Evolution of Environmental Evaluation Procedures in South Africa, University of Cape Town, Rondebosch, South Africa, Elsevier Science Inc.
Swilling M. (n.d.) Greening Public Value: This Sustainability Challenge, in Bennington J and Moore M In *Search of Public Value: Beyond Private Choice*, London: Palgrave
Swilling M. (ed) 2010 *Sustaining Cape Town – Imagining a Livable City*, Sun Press-Sustainability Institute, Stellenbosch
Terreblanche S. 2005 A History of Inequality in South Africa 1652 – 2002, University of Natal Press and KMM Review Publishing, Pietermaritzburg
Terreblanche, S 2012 Lost in Transformation – South Africa's Search for a New Future since 1986, KMM Review Publishing Company, Johannesburg
Todes A 2013 Spatial Targeting: Lessons from South African Experience, Background Report for the Cities Support Programme (CSP) Workshop on Spatial Targeting, 3 to 4 October
Turner, R 1978 The Eye of the Needle, accessed from http://www.siyathanda.org.za/attachments/article/106/55744023-The-Eye-of-the-Needle-by-Richard-Turner.pdf
Urban Foundation, 1987 Seminar Series on legal Changes in Black Housing, Seminar Notes
US Green Building Council. 2008, Building Impacts. Accessed from http://www.usgbc.org/DisplayPage.aspx?CMSPageID=1720, quoted in CSIR 2008 Design Guidelines for Energy Efficient Buildings in Johannesburg, City of Johannesburg, Gauge
Vally, N 2009. National trends around protest action: mapping protest action in South Africa, Study undertaken on behalf of the Centre for Sociological Research (CSR) and the Freedom of Expression Institute, presented to CSR and Development Studies Seminar

Van Aswegen, HJ 1970 The Urbanisation of Non-Whites in the Orange Free State, 1854 – 1902, SA Historical Journal, Vol 2, Issue 1 (Nov) 19-37. (published on-line 14 January 2009)

Wilkinson P. 1981 A Place to Live: the Resolution of the African Housing Crisis in Johanesburg 1944 to 1954, paper presented at *African Studies Seminar, African Studies Institute*, University of the Witwatersrand, Johannesburg, July

Wilkinson, P 1998 Housing Policy in South Africa, in Habitat International, 22, 3, 215-229, available on line at
http://www.sciencedirect.com/science/article/pii/S0197397598000010

Endnotes

1 Cf. Hendler, 2013: Personal communication with Professor Francois Viruly, Property Specialist, March 2013

2 On 1 May 1979, the first interim report of the Wiehahn Commission was tabled in Parliament. The Wiehahn Commission was set up by the government after the Durban strikes of 1973 and the Soweto uprisings of 1976 to look at industrial relations system in South Africa.

3 The government appointed the Riekert Commission to consider ways of adapting the influx control laws to meet rapidly changing economic and political challenges.

4 See Hendler (1993: 378–387) and Hendler and Spiropolous (1991) for a further discussion on the details and contradictions inherent in community participation, residential planning and product delivery.

5 Fine (n.d.) refers to illegal capital flight from South Africa as a percentage of GDP rising from 5,4 per cent between 1980 and 1993 to 9,2 per cent between 1994 and 2000. He also notes Treasury reporting that indicates that between 1991 and 2000 there was an overall nett foreign direct investment (FDI) outflow of R386 million per quarter and that the total stock of outward FDI had grown from $8,7 billion in 1995 to $28,8 billion in 2004. Fine (n.d.) also aligns the value of unbundling of conglomerates at R80 billion in 1999 with the 1998 raising of the limits of investments abroad by local conglomerates to R50 million per company, and the expansion of the financial sector to 20 per cent of GDP by 2007 and its rate of expansion being twice the rate of GDP.

6 Terreblanche (2012: 3, 6, 69) argues that the ANC government was in a relatively weak position in 1994, 'as its sovereignty was fairly seriously restricted by the conditionalities that were made applicable when our economy was integrated into the structure of global capitalism'. Terreblanche adds that through leading ANC figures receiving 'ideological training at American universities and international banks', pressure from Western governments and international institutions (like the IMF and World Bank) as well as secret negotiations (held at the Development Bank of Southern Africa) the ANC was brought over to the view that neo-liberal globalism and market fundamentalism would be economically advantageous for South Africa – the new governing elite also had definite material interests in participating in this process through being empowered to allocate affirmative action and affirmative procurement contracts.

7 Terreblanche, 2005: 393; for 2011 figures see Appendix

8 Noseweek. 2013. 'Here comes the poison', 10–13 April 2013, p. 12.

9 Transkei/Venda/Bophuthatswana/Ciskei

10 Based on consulting services provided to several metropolitan municipalities in terms of the CSP.

11 Noseweek. 2015. 'A plague on frogs – and the people of Polokwane – Nature buffs unearth dark secrets of dodgy property deals', 20–23 May 2015.

12 Segar S. 2013. 'Wonderwoman – Gauteng's last hope', Noseweek, 14–16 April 2013; Noseweek. 2013. 'Here comes the poison', 10–13 April 2013, p. 12.

13 Groundwork. 2014. 'Shell: don't frack the Karoo', available on line at https://milieudefensie.nl/publicaties/rapporten/shell-dont-frack-the-karoo.

Between the Clinic and the Community: Temporality and Patterns of ART Adherence in the Western Cape Province, South Africa[1]

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Abstract:

In an ethnographic study conducted over thirty months in South Africa's Western Cape Province ending in 2012, we explored ART adherence amongst almost 200 patients attending three clinics. This setting contained significant political, structural, economic and socio-cultural barriers to the uptake of, and adherence to, treatment. Such barriers certainly impacted patient drug use and the labelling of clients as 'adherent' or 'non-adherent'. Yet, as our fieldwork developed, it became apparent that these labels also bore little relationship to the amount and regularity of drug consumption outside the clinic. Indeed, the people that we knew moved through these labels in ways that could not simply be explained by brute socio-economic circumstances, poor understanding of the functions of the drugs, or varying levels of family and community support, which themselves often changed over time. This paper presents four on-going 'patterns of adherence', which are clearly discernible in the communities in which we worked. Each pattern is demonstrated through the life of an 'index patient' whose case is seen to be representative of the range of experiences and practices observed under the terms 'adherent' and 'non-adherent'. We argue that such terms are deeply contextual and, crucially, temporally situated. The complex intertwining of political, economic, socio-cultural, gender, and biological factors that constitute the lives of participants exists in time and we call for a focus on evolving lives in relationship to changing health systems that can follow (and respond to) such developments to better deliver both information and services.
Key words: *ART adherence, community, health systems, socio-cultural barriers drug consumption*

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Résumé

Dans une étude ethnographique menée sur trente mois dans la province du Cap occidental en Afrique du Sud se terminant en 2012, nous avons exploré ART adhésion parmi près de 200 patients fréquentant trois cliniques. Ce paramètre contient obstacles politiques, structurels, économiques et socio-culturels importants pour l'absorption et l'adhésion au traitement. Ces obstacles certainement touchés usage de drogues patient et l'étiquetage des clients comme «adhérent» ou «non-adhérent. Pourtant, comme notre travail de terrain développé, il est devenu évident que ces étiquettes portaient aussi peu de rapport avec la quantité et la régularité de la consommation de drogue en dehors de la clinique. En effet, les personnes que nous connaissions déplacé à travers ces étiquettes d'une manière qui ne pouvait pas simplement être expliquées par les circonstances socio-économiques brute, une mauvaise compréhension des fonctions de la drogue, ou des niveaux variables de la famille et le soutien de la communauté, qui se souvent changé au fil du temps . Ce document présente quatre en cours "motifs d'adhésion», qui sont clairement visibles dans les communautés dans lesquelles nous avons travaillé. Chaque modèle est démontré à travers la vie d'un patient de l'indice 'dont le cas est vu pour être représentatifs de la diversité des expériences et des pratiques observées en vertu de l'adhérent »et de« non-adhérent. Nous soutenons que ces termes sont profondément contextuelle et, surtout, située temporellement. L'enchevêtrement complexe de politique économique socio-culturelle, de genre, et les facteurs biologiques qui constituent la vie des participants existe dans le temps et nous appellent à une mise au point sur l'évolution de la vie dans la relation à l'évolution des systèmes de santé qui peuvent suivre (et de répondre aux) tels développements pour mieux offrir à la fois des informations et des services.
Mots clés: *ART adhésion , la communauté, les systèmes de santé , les barrières socio- culturelles la consommation de drogues*

Introduction

This paper traces actual antiretroviral (ARV) usage in the lives of people living with HIV in situations of often-extreme structural violence, alongside their relationships to the medico-bureaucratic labels that form the portal to their life-saving medication. We centre our observations and analysis on the moving interface between clients and clinics, a membrane where multiple agencies and logics – in the shanty, in the clinic, and indeed globally - intersect over time, but which are usually tracked in a series of snap-shots, reducing them to seemingly clear categories of 'adherent', 'non-adherent' and 'lost to follow-up'. Such labels are not trivial, as they position individuals in ways that impact everything from their continuation on these drugs to understanding the effectiveness of treatment at regional, national, and global levels. At the same time, these labels are not simple: they shift over time and with respect to scales of analysis. Crucially, the same label can also cover very different patterns of actual drugs usage, while similar patterns of partial usage are sometimes discriminated through

different labels. We conclude that this complexity requires much closer ethnographic and theoretical attention and we suggest that the interface between the clinic and community should be the focus of this attention.

We start by locating some of the larger discussions of adherence in powerful discourses that provide funding for programmes and survey their results. In doing so, we chart some of the complexities of surveillance and reporting categories upon which so many lives ride. We then chart in our own work some of the ways that distinct lines are drawn between very similar patterns of the use of these medications while at other times very different patterns of use appear in the same category. At the same time, we reveal surprising levels of movement between seemingly neat categorizations that eventually code (in clean statistical tables projected in well-appointed conference rooms) the impact that these drugs are having. It is only when snap-shots are put back into social motion that can we see how important time is in understanding this complex social-medical situation. We offer this analysis not as a critique of global antiretroviral treatment (ART) policy, but as an encouragement for ethnographers to engage more directly the temporal aspect of ART, especially as reinvigorated focus on health systems is emerging as a significant issue in Public Health and Global Health.

Background

While the history of the struggle to gain popular access to antiretroviral treatment (ART) in the Republic of South Africa is well known in the literature, it still seems useful to review some of the highlights of this success here. After sustained pressure from civil society organizations and the breaking of the Northern-held patent on antiretroviral (ARV) medication in 2001, the South African cabinet committed the government in 2003 to a public sector antiretroviral treatment ART rollout. By the end of 2013, over 2.5 million people were receiving ART (SA Dept. of Health, 2013-2014), and South Africa is now widely acknowledged to have the largest and best-established antiretroviral treatment programme in the world.

Since the 2003 rollout of ARV medication in South Africa, HIV has for many people changed from being a fatal disease to becoming a manageable chronic illness (Mitchell & Linsk, 2004). However, the successful management of this chronic illness is strongly dependent on the patient's adherence to ARVs. An optimal adherence rate of 80-95% is required if medication is to be successful and the desired outcome – slowing the progression of the illness and decreasing morbidity and mortality rates from secondary infections – is to be achieved (Garcia & Cote, 2003; Battaglioli-DeNero, 2007; Shah, 2007; Ingersoll & Cohen, 2008). Sub-optimal adherence to antiretroviral treatment can cause treatment failure and, potentially, drug resistance, so we observe a wide variety of interventions in Public Health to assure as full adherence as possible in a population using ART.

Western Cape Province, in partnership with Médicins Sans Frontières, launched the first highly active antiretroviral treatment (HAART) program in May 2001 in defiance of national policy (Naimak, 2006). By March 2003 the province announced that all HIV-positive pregnant women could access the antiretroviral drug, Nevirapine, at their nearest clinic. The current HIV prevalence in the province is 18.2% (approx. 1,055,600 people) (http://www.avert.org/south-africa-hiv-aids-statistics.htm) with a reported 156,703 patients in the province receiving ART at the end of 2013 (Western Cape DoH 2014: 212).

ART suppresses the virus and reduces viral replication to undetectable levels, turning a disease that had once been rightly feared as a death sentence into a chronic condition, potentially granting decades of life. However, in order for the treatment to be effective, a high rate of treatment adherence is required. The consequences of non-adherence, at the individual level, are a faster progression to full-blown AIDS, a much more expensive treatment regimen as other drugs are prescribed to stem the rising viral load, and potentially treatment failure and death. The Public Health fear is that incomplete adherence on a large scale could potentially produce very resistant strains of HIV, reversing the remarkable success story in the control of this plague in the last twenty-five years. Thus, the massification of ART resulted in increasing research on how to get people to become and remain 'adherent', and programme effectiveness is judged by the proportion of people who inhabit this category.

Adherence as an Optic and a Goal in Global and Public Health

From the innovation of HAART in the early 1990s, *adherence* emerged as a key health and policy issue. Patients needed to take their medication exactly as prescribed, while also following the necessary dietary restrictions. The 2003 World Health Organisation report - *Adherence to Long-term Therapies: Evidence for Action* states that adherence is not only about taking medication properly, but also about behaviour, including arriving for appointments at the healthcare facility. Thus adherence is defined as 'the extent to which a person's behaviour - taking medication, following a proper diet, and/or executing lifestyle changes - corresponds with agreed recommendations from a health care provider' (2003: 17). Therefore, adherence is also closely linked to the issue of accessing medication and using it properly, even if it is not completely co-terminus with drug use (Reif et al, 2005). Indeed, for many people in need of ART, the process of accessing health facilities still serves as a great barrier to adherence (Reif et al., 2005; Tuller et al., 2010).

After the breaking of the Northern patent on ART and the massification of this therapy, adherence emerged as a global concern, as funders and Global Health decision-makers searched for ways to measure impact and understand unmet needs. This added

another definitional layer around "adherence". For example, "full coverage" is defined by the WHO as getting ART to 80% of those in need in a population. The data from four-year follow-up studies throughout the world, however, shows that adherence 'trajectories' tend to track downwards over time, with adherence rates after four years falling to around 70% at the end of most of these studies (UNAIDS, 2012). In other words, in most resource-constrained settings, almost half of the people who might imagine themselves to have access to this form of therapeutic citizenship still do not (or have fallen out of this status) after only four years in populations deemed 'adherent'.

These disparities present disquieting theoretical challenges, as scholars try to tease out ideas of discipline, medical necessity, and various understandings of agency in radically different settings, with literally life-and-death stakes in play. In this debate "adherence" jostles with seeming synonyms, such as "compliance" to mark out different understandings of how the life-world of patients relates to ART. Historically, some studies argued that adherence is the same as compliance (Shah, 2007; Ingersoll & Cohen, 2008), while others (Kaijee & Beardsley, 1992; WHO 2013) argue that the two are entirely different concepts, with 'adherence' being the more appropriate term. Kaijee & Beardsley (1992), on the other hand, point to the medically defined concept of 'compliance' as uni-dimensional and as a failure to recognize the patient's agency. WHO (2013) argues that while the relationship between the healthcare provider and the patient must be a partnership during which the treatment process is discussed, 'compliance' implies that patients are passive participants in their treatment process, and does not acknowledge the necessity of such a partnership.

Maskovsky (2005) also challenges this emphasis on 'adherence' rather than 'compliance', which he argues 'places the burden – and much of the blame – for the failure of HIV drugs on the people who take them' (see also Mattes 2015). As Crespo-Fierro (1997) notes, the reasons for non-adherence are generally multifaceted. Factors that negatively impact on adherence to ART are generally categorised into four groups - disease-related, patient-related, provider-related and treatment-related (WHO, 2003; Hardon, et al, 2007; Bardel et al, 2007; Spire et al, 2002; Hubbard, 2006). Linguistic and communication factors, such as those highlighted by Penn et al (2011) have also been pointed to as issues in adherence. There is also the significant issue of the political economics of access (Nattrass, 2008) or the political decision-making processes that place voter interests ahead of patient need (Bruera 2006) in the distribution of scarce resources.

We also have detailed ethnographies of people with HIV trying to access treatment, and indeed health, in extremely trying circumstances (see especially Biehl 2007, Zigon 2010). In such work, however, the clinic is constructed as a semi-opaque bureaucratic structure, and we are unclear how the messy complexities we see in the ethnography are structured into the reporting categories that inform donors and international health organizations of the effectiveness of their interventions, while the ethnography

beautifully (if tragically) documents often very partial adherence. In other words, the question is not just the 'limits of surveillance' in Biehl's apt phrasing (2007:179-180), but also understanding the specific means through which surveillance as such is enacted in particular times and places in relationship to actual patterns of drug use.

Factors Explaining Non-Adherence

Disease-related factors

Adherence to medication is poor when the illness is asymptomatic and chronic. Advanced illness as well as exposure to painful symptoms and side effects may result in a greater likelihood of the patient following the treatment as prescribed (Abel & Painter 2003, Battaglioli-DeNero 2007, Gay et al 2010). In one American study, disease severity was identified as playing a key role in adherence, as patients who have experienced complications from the disease may believe that they are at greater risk of their disease getting worse if they do not adhere to ARVs (Gao et al, 2002). On the other hand rumours of bad side-effects discourage attendance among some (Grant et al 2008) while in the South African context, early political equivocation regarding lay and untested HIV remedies led many to explore these options instead of, or alongside, their ART treatment (Mills 2008).

Patient-related factors

Acceptance and disclosure of the disease facilitates support from family and friends, which can impact positively on adherence (Battaglioli-DeNero 2007). Culture, religion, health beliefs, health practice and motivation can have both a negative and a positive impact (Ezekiel et al. 2009, also Russell and Seeley 2009). Kalichman et al (2005) identified the need to develop the adherence skills of patients, and provide devices or strategies to help adherence. Failure to fill prescriptions, missing and forgetting doses (Katzenstein, 1997), incorrect dosing and self-regulating the regimen to manage side effects are additional negative factors (WHO, 2003; Hardon et al, 2007; Nam et al, 2008). Other factors identified, which contribute to poor adherence, were stigma, hunger, transport cost (accessing healthcare facilities) and substance abuse, including alcohol consumption (Reif et al, 2005; Conen et al, 2009; Hardon et al, 2007).

Provider-related factors

In attempting to address adherence, studies often focus on patient-related adherence factors rather than provider-related adherence factors. With the increased prevalence of HIV, healthcare systems have become overworked and understaffed. This has resulted in a lack of counselling expertise and time to counsel patients properly. Linguistic barriers may impede communication of treatment regimen; therefore language and literacy issues, particularly in multilingual sites such as Western Cape, are often seen to impede the provision of equitable care (Deumert 2010, Penn et al 2011). Where there is ART regimen complexity providers need to tailor regimens to individual lifestyles (Battagliolo-DeNero 2007). An overestimation of adherence readiness and willingness may result in inaccurate adherence predictions, as patients may not fully comprehend their regimens (Ingersoll & Cohen, 2008).

The quality of healthcare provider (HCP) communication with the patient, is an important determinant of adherence (Abel & Painter 2003, Hargie 1999, WHO 2003); and thus of the actual therapeutic process and behaviour. Tugenberg et al. (2006) found that patients' relationships with HCPs played an important role in patients' non-adherence and the disclosure thereof. Participants in this Massachusetts-based study confirmed that the emphasis and 'insistence' on adherence sometimes had the opposite effect, and that non-adherence is often not disclosed due to concerns of being seen as a bad patient or to avoid being reprimanded. Lack of disclosure of non-adherence was also a way to avoid 'disappointing' the HCP (Tugenberg et al, 2006).

Treatment-related factors

Poor adherence can be due to the complexity of the regimen, dosing times and the number or variety of pills the patient has to take (Battagliolo-DeNero, 2007; Gallant, 2002; Ingersoll & Cohen, 2008). Generally, if a dosing schedule that coincides with daily routine has not been planned and implemented, difficulty in adherence to treatment is likely to occur.

Thus, adherence has a dual quality in the literature; that is, it exists as both a state and a process (Gray 2006). Patients' lives can display, at different times and in different circumstances 'erratic non-adherence', 'unwitting non-adherence' and 'intelligent non-adherence' (Donovan & Blake 1992), but at any moment in time there are a very limited number of ways to view and tabulate these patterns. To this extent, it seems that a much more serious engagement is required with the relationship between temporality, actual use of medication, and the clinical gaze.

Methodology

We worked over a period of 30 months from 2009, in the West Coast region of Western Cape Province (Saris et al, 2012). The three ART clinics that form part of this study have a catchment area of approximately 450km, with a population of close to 500,000. In June 2009 those three clinics combined had 1,212 people (1126 adults and 86 children) attending for antiretroviral treatment (Western Cape DoH, personal correspondence, June 2009). Province-wide during 2009 approximately 2,500 people were being initiated onto antiretroviral therapy per month, and it was anticipated that this number would need to be maintained for 3-5 years (Western Cape DoH Annual Performance Plan 2011/2012).

In addition to the three ART clinics, our research site included ten referring primary health care clinics (PHCs), five Non Governmental Organisations (NGOs) who provide outreach services, and the homes of numerous people on ART. Outreach staff were instrumental in introducing us to HIV-positive participants who were not attending the clinics and therefore were deemed 'non-adherent', so we had regular access to some patients that the clinics themselves wanted to bring closer. In other words, our team had a presence in all of the formal clinical settings people accessing ART could attend as well as having a presence in their homes and local communities. Thus, we were able to follow not just people, but also information and objects (especially pharmaceuticals), repeatedly across the interface between the clinic and the community.

Patient participants were recruited through both convenience and purposive sampling at ART clinics or through outreach workers in the community. In addition to patients, a total of 36 health worker participants (doctors, nurses, pharmacists, support staff, outreach workers, etc.) were purposively selected on the basis of their stakeholder status and their ongoing interaction with patients. The principles of written informed consent were applied in all cases.

Ethical approval was obtained from the Western Cape Provincial Department of Health, from University of Western Cape, South Africa and from Maynooth University, Ireland. Permission to engage with ART and PHC clinics was gained from the Regional Director initially and from each individual hospital/clinic/NGO.

Methodological, data and investigator triangulation processes (Guion, 2011) were adopted, to ensure validity of data. Initially patients consented to one-to-one, semi-structured interviews in their language of choice[2]. Once an initial interview was complete, all participants were asked for further permission to continue engagement with them. For patients attending an ART clinic this involved a researcher who 'shadowed' them during interactions with the various health professionals (doctors,

2 *Of the eleven official languages in South Africa, Afrikaans, English and isiXhosa are the official languages of Western Cape Province. All of our research team are fluent in at least two of the three official languages.*

nurses, pharmacists, ART counsellors, etc.)[3]. This facilitated observation and recording of patient experiences as they moved through the treatment pathway. Participants who were not engaged with services were asked to continue speaking to our researchers at their own discretion. Many patient participants gave permission for multiple follow-up meetings and shared their stories with us through conversations and interviews either at the clinic, at their homes, or at a place of their choice.

All formal interactions were digitally recorded, transcribed in full and, where appropriate, translated into English, which was the working language of all team members. A portion of the transcriptions were also then back-translated from English to Afrikaans or English to *isi*Xhosa for verification of the translation process. Researchers had the opportunity to observe daily activities at each of the clinics over a number of months, and these were recorded in field diaries, which, along with interview notes, formed part of the data set. A thematic analysis was then conducted using cyclic three-step analysis - open coding, followed by axial coding, followed by selective coding (Strauss and Corbin, 1990) and AtlasTi was used to manage data sets. Finally, 22 'index patients' were identified whose cases typified the broader patient base in terms of their (non)adherence patterns. Four clear patterns emerged which were developed into brief representative case studies.

Once these representative case studies were completed a series of workshops was held where our data and provisional conclusions were presented to a cross section of participants (patients, health workers and NGO staff). This allowed participants the opportunity to give feedback about the findings, and to contribute to the interpretive process. Each of the patterns presented below was endorsed as an accurate representation of the lived experience of HIV-positive patients in the region.

Patterns of Adherence as Ethnographic Data

The case studies below are drawn from the 22 index patients, which were chosen as representative of patterns of adherence amongst our participants. They demonstrate the complex intertwining of political, economic, social-cultural, gender, and biological factors that impact the experience of living with HIV, as well as access and adherence to treatment. Many of these barriers cannot always be so clearly delineated, as they bleed into and influence each other. Others clearly have a top-down or bottom-up impact on how services are provided and on how service users access and understand their treatment. In concrete social-historical circumstances, these factors meet at the interface between logics and optics in the clinic and the resource constraints, expectations, even the resilience of real people. This interface exists in time, however, and very often the same behaviour, object, or idea changes its valence, sometimes dramatically, while people negotiate their relationship to different bureaucratic categories.

3 *The healthcare worker's permission was also requested in such instances.*

All participants have been anonymised and pseudonyms applied.

Benjamin's story, RIP (Adherent - Lost to Follow-Up):

The 'treatment holidays' patient (six months on/six months off, or nine months on/three months off)

28 year-old Benjamin was wheelchair bound when we were first introduced at an ART clinic; extremely weak and frail, he was living at his mother's home in the West Coast region. Benjamin had attended primary school but his family could not afford his attendance at secondary school. We subsequently met with him at his mother's home and at the clinic on numerous occasions.

Benjamin tested HIV and TB positive nine years previously, and was successfully treated for his TB before beginning antiretroviral treatment for HIV. His treatment initially caused upsetting side-effects - a rash on his chest, under his arms and on his private parts, and lumps on his leg, under the skin. No medication was made available to him for the side effects but his mother treated these with ointment and he persevered with his ART and slowly began to feel better. For Benjamin, as for others we spoke to, it was when he started feeling well again that he stopped taking his medication. Travelling to the Northern Cape Province he found temporary work until his condition deteriorated and he sought treatment at a local clinic. Unfortunately for reasons that were unclear to Benjamin, his initiation onto second line treatment was delayed in the Northern Cape continuously and in desperation he returned to the West Coast district where he had first been treated in the hopes of receiving second line treatment. This is where we met.

In the year after our initial meeting, Benjamin's progress on treatment was sporadic. His weakened condition made eating difficult and he was given nutritional supplements to drink with his medication. He was admitted to an isolation ward in hospital for five days after again contracting TB, although thankfully not a drug-resistant form. He was also diagnosed with epilepsy and was being treated for this condition while continuing on ART. Over the time we knew him, Benjamin reported feeling better and gradually was able to move about without his wheelchair. Under his mother's care, and with the clinic's assistance, his condition improved, although he remained silent, withdrawn and extremely thin.

Suddenly we received news that Benjamin had once again left the district to return to the Northern Cape. The staff at the clinic expressed disappointment as they felt that, although improved, his condition was not stable enough to once again leave their care, but he had not consulted with them before he left.

For reasons that are unclear, Benjamin once again stopped taking his ARVs when he got to the Northern Cape. We received word that he had passed away approximately one year after our first meeting.

Understanding Benjamin

A number of issues arising out of Benjamin's story have a bearing on his adherence pattern. While living under the close scrutiny and vigilant care of his mother, Benjamin's condition improved. Indeed, because of the social support available

to Benjamin, through his mother's care, the clinic were more inclined to provide additional assistance – they arranged to have his medication delivered to a clinic closer to Benjamin's home, and they provided nutritional supplements to Benjamin that were not given to other patients.

Once his condition improved, however, Benjamin repeatedly left his mother's care to return to his life in Northern Cape. Once there, he did not/could not access medication and his condition would deteriorate. Lima et al (2008) found that individuals migrating at least three times were 1.79 times more likely to be non-adherent than individuals who did not migrate.

It is not uncommon for patients to stop taking ARVs when their condition begins to improve. While medical staff stress that there is no cure for HIV, this is a problematic notion for some. This may relate to a straightforward matter of translation as for some local languages the word for 'treat', 'heal' and 'cure' is the same, and the distinction that is made in English does not translate properly. But the concept of a non-curable disease is also problematic, as Murray et al (2009) found in their study amongst Zambian women. Why should one continue to take medication if one is 'better'? For these patients, it is not until their condition deteriorates again (some months later) that they realise they need to go back to treatment. Nor is it particularly uncommon for this cycle to be repeated, deliberately or through unavoidable life circumstances. Such 'treatment holidays', when unplanned, can result in the emergence of HIV isolates resistant to ARVs (Katzenstein, 1997).

The inequity in treatment facilities in various parts of the country also has a bearing on Benjamin's adherence. The ART rollout programmes in the Western Cape and Gauteng provinces are renowned countrywide for being efficient and effective. Internal migration for treatment purposes is not uncommon. However, patients regularly leave the district for up to three months at a time (for seasonal farm work, during holiday periods or to attend traditional family events) and are often unable to access elsewhere the high levels of treatment they have come to enjoy in Western Cape. This poses difficulties for the clinics in each district. Western Cape clinics are reluctant to provide patients with bulk medication for an indeterminate period, unless they have established an exceptionally good working/treatment relationship with the clinic. For the clinic in the host communities, these 'visiting' patients can often not be accommodated because of lack of resources, shortages of medication, insufficient medical histories, etc.

Further challenges arise for patients who wish to transfer to another health facility when life circumstances change. These moves could be in pursuit of employment opportunities, forced by changing home situations, or simply wanting to start afresh with the new lease of life received from successful treatment. Whereas a province like the Western Cape has a well-resourced health system and boasts a computerised district health information system, the reality on the ground is that this system does not allow

for the ease of transfer of patients between facilities, even within the same district, because much of the patient information is still only in paper format (patient registers and folders).

Benjamin's recorded status with the clinic moved from 'adherent' to 'lost to follow-up' before word was received that he had passed away.

Gabriella's Story (Non-adherent – Adherent)

The 'partying' patient (six days on/one day off)

Gabriella was a 42-year old woman born in a rural part of the Northern Cape Province. She attended school there until the age of 10, but migrated to Western Cape in 1997 to find work. Her home was a shack in an informal settlement about 3km from her local ART clinic, where she lived alone. She had limited contact with her adult children who had moved away from her since discovering her HIV positive status.

Unemployed, Gabriella sometimes had casual work as a domestic servant for a few hours a week. Friends and neighbours offered food or money but she was reluctant to receive favours, preferring to do some small amount of housework for them rather than accept charity. Her absent boyfriend sent money erratically. When we first met it was 4pm in the afternoon and Gabriella had not eaten since breakfast the previous morning.

Gabriella became emotional as she recounted in vivid detail how she received her diagnosis for 'this illness'. Herself and her boyfriend both tested positive at the same time in 2008. 'They came back with coffee and two slices of bread' she said 'and the doctor came and looked at me...gave me a letter...told me that I am HIV positive'. Three months later, with a CD4 count of 145 cells/µl, Gabriella was started on ARVs.

Anxious to assure the researcher that she understood her treatment regimen, Gabriella took her tablets out of her bag to show which ones are taken at which times of day. The pills were muddy, as though they had been dropped or handled repeatedly. We established that adherence has not always been ideal and that Gabriella's pattern of adherence had changed substantially over the 18 months since she began treatment.

- Severe side effects (sore body, itching, dizziness, double vision, night sweats) in the early stages of treatment caused Gabriella to stop taking her medication properly. These side effects continued even after medication had been prescribed to relieve symptoms.
- At one stage Gabriella felt life wasn't worth living because her children didn't want to know her and she felt they didn't care, so she stopped taking her medication for a month. Gabriella went back on the treatment when she began to feel really sick.
- Numerous medical staff instructed Gabriella not to drink alcohol while taking her medication. Therefore, when she partied, or planned to drink, she did not take her medication. Nor did she take a double dose the next day; just skipped a dose.

Understanding Gabriella

Gabriella's case is typical of those patients whose adherence pattern changes considerably over the first year of treatment before settling into a less than ideal semi-adherent pattern.

No individual screening is conducted before initiation on first line ARVs to establish the potential extent or severity of side effects. Information regarding side effects is not always forthcoming, with Clinic counsellors and home-based carers expressing concern that patients will not take the medication if they know how severe the side effects might be. Instead, counsellors often 'drip-feed' information about side effects to patients as required, in the hope that they will not be discouraged. Patients who do experience side effects may stop taking their medication completely without ever returning to the clinic again. Where patients show willingness to persevere, the clinics will attempt to either treat the side effects, or provide alternative ARVs to reduce the impact. In Gabriella's case her pill burden increased substantially and the side effects were reduced, although not eliminated.

Depression and feelings of loss are not uncommon amongst patients given a diagnosis of HIV. As family relationships broke down, Gabriella stopped taking her medication because she said she 'wanted to just die'. Ammassari et al (2004) and Battaglioli-DeNero (2007) report on the negative impact of depressive symptoms on ART adherence. Ironically, Gabriella reported that it was after she stopped taking her medication and her condition deteriorated substantially, that her daughter began to re-engage and they started to mend their relationship.

Gabriella's pattern of adherence is extremely common amongst patients in the Western Cape region. Patients are repeatedly told that they should not drink while they are taking ARVs. There are several reasons for this: ARVs have the potential to cause liver toxicity and this is exacerbated by alcohol abuse; excessive alcohol consumption may increase the risk of non-adherence as people forget to take their medication, or the affects of the alcohol (or indeed recreational drugs) can inhibit the effects of ARVs. However, it is generally accepted internationally that failing to take a dose of ARVs, or erratic adherence, can cause more harm than taking ARVs with alcohol. Many of the nurses and counsellors currently working with HIV patients would previously have been trained in TB care, which requires that patients remain completely alcohol-free while taking their medication. This instruction appears to have been carried over to the treatment of HIV. Also, given the region's difficult history with alcohol and the high rate of alcohol abuse and foetal alcohol syndrome (FAS) amongst the local population (McKinstry 2005, London 2000, Olivier et al 2013), there is a genuine antipathy towards any alcohol use amongst many of the healthcare staff, and particularly nurses, in local clinics. Finally, the information currently provided to patients regarding ARVs and alcohol consumption could be interpreted as a medical care rationing decision on the part of the Government, rather than a decision based on clinical outcomes.

The clinics in the Western Cape use a 'teach back' technique to inform their patients in an effort to ensure that the patient is not a passive recipient of knowledge, but an active participant in the treatment process. This requires that the patient repeat back to the counsellor the information he or she has received, in order that the counsellor can see whether they have received the information correctly. Watermeyer & Penn (2008) describe the same process being used amongst pharmacists dispensing ARVs in Johannesburg. However, the manner in which patients repeat (verbatim, and with gestures) the information they have been given about alcohol avoidance, suggests that they do not fully comprehend the reason for avoiding alcohol. While alcohol is central to social life in the area, there is little tolerance on the part of health workers for even moderate alcohol use. One of our researchers witnessed an adherence counsellor refuse to recommend a patient for treatment on the basis that *her husband* drank alcohol. Gabriella only drank on Saturday nights, but was said she was 'afraid' to take her medication when drinking because she had been told it was 'very very bad'. Instead, as is the case with many others, her pattern of adherence was to take medication from Sunday to Friday only.

Gabriella was initially recorded as non-adherent, but, later, with little change in her drug-routine, she was labelled adherent.

Neville's Story (Adherent)

The 'playing' patient (5 ½ months on/two weeks off)

38 year-old Neville lived in his sister's home close to one of the ART clinics when we first met. He was introduced to two of our researchers by outreach staff who were concerned about his adherence. Both his parents were deceased and he had no partner. His sister had taken him in but their relationship was not good and money worries added to the difficulties. Having tested HIV and TB positive in 2008, Neville was granted a temporary (six month) social grant, which was due to end within 3 months of our meeting. This was a cause of enormous concern for Neville who repeatedly asked for help with retaining his grant. The grant paid for bills for himself and his sister and sometimes there was no money left for food. He generally borrowed money for food and was concerned about what would happen when the grant finished. His repeated question '*Wat moet ek maak, wat moet ek maak?*' (What must I do?), lent an air of desperation to his conversation.

Neville explained to us his treatment regimen. Taking a handful of tablets that he was carrying loosely in his pocket, he correctly identified the ARVs and explained (incorrectly) that he should take them at 12 noon and 7pm, and had already taken his TB meds at 7am this morning. In fact ARVs should be taken at 12-hour intervals and

the TB meds can be taken separately. He was also taking medication to counter side effects of the ARVs and had been told to continue taking it although he said it didn't work. It soon became apparent that Neville was attending three clinics in three different jurisdictions, though he could not clearly explain why this was the case. It appeared that one clinic was treating his HIV, another his TB and the hospital was treating Neville for cancer.

As we met with Neville over the following months, his situation deteriorated rapidly. The relationship between himself and his sister broke down completely and he was now living alone. He struggled to get money but sometimes got a bit of gardening work, which provided intermittent income. In addition, the hospital he had been attending had confirmed a diagnosis of cancer, but Neville was unable to provide any further information on this. His social grant was not renewed and the letter he received (which we were shown) did not explain why. He was given leave to appeal the decision of the SASSA (social welfare) and was planning to do so with the help of an outreach worker.

Understanding Neville

When patients are initially put on ART they most often present with a WHO Stage III HIV illness, i.e. they had at that time (pre 2010) a CD4 count of ≤200 cells/µl.[4] Patients are informed that they qualify for a grant as they are medically unfit to work. The CD4 count in itself does not render a patient medically fit/unfit to qualify for a grant. However, those with low CD4 counts in most cases experience a decline in their health – hence the reporting to the health setting. It is this concomitant factor that leads to the physician motivating for the disability grant on the basis of HIV defining illness. As the importance of the CD4 count is impressed on the patient in a variety of settings they come to believe, with some justification, that a CD4 count of ≤200cells/µl is *the* measure that determines their eligibility for a welfare grant. Patient CD4 count is checked every three months. It is envisaged that this check would indicate whether current treatment is working; soon after ARVs are instituted CD4 counts can be expected to rise and viral load reduced so low as to be undetectable. An increase in CD4 count would indicate that the person's immune system is getting stronger and HIV viral replication is suppressed. A stronger immune system would also indicate that the person is getting stronger (and potentially on the way to becoming economically productive).

The timing of a CD4 count blood test generally coincides with the renewal date of a social grant. For some patients, the grant has become a *de facto* poverty alleviation grant and they are unable to cope financially without it. They therefore begin to 'play' with their medication, in an attempt to 'manage' their CD4 count and thus retain their social

4 *In July 2014 the National DoH changed its national guidelines to raise the threshold for initiation of ART at a CD4 count of ≤500cells/µl, effective January 2015. (SA DoH, 2014: 14). How this will impact patient's perception of their access to the grant is something that should be followed.*

grant.[5] The most common form of 'playing' with medication in such situations is to take pills only every second day; or to stop taking them completely in the days coming up to a blood test. The clinic checks adherence based on a medication count conducted during the normal check-up, but medication counts ignore medication complexity (Libby et al 2013) and do not confirm that a patient has in fact consumed the medication; merely that he/she has removed the medication from the package. We found patients in extreme circumstances will throw their medication away, flush it down the toilet or (in one case) keep it safely in a separate glass on a dresser.

Neville's attendance at a variety of different healthcare settings also served to confuse him with regards to his medication. The local ART clinic that Neville attended had considerable difficulties with retention of medical staff in the previous two years. This is in large part due to a systems failure within the organisational structure of the rollout programme of the district. The result is that over a six-month period in 2009 there were five different doctors in the clinic and for long stretches of time the clinic had no doctor at all. Over the period in question the clinic staff reported that up to 100 patients had been 'lost to follow-up'. Local newspapers carried reports from patients who expressed their concern at the breakdown in service at this clinic, and many patients sought services at clinics in neighbouring jurisdictions. The failure of the clinic service itself presented a barrier to adherence for the patients in this instance. Neville was caught up in this situation, unable to find a doctor who could cater for all his needs and receiving contradictory information regarding his treatment regimen.

Poor service delivery, low levels of treatment literacy, an extremely complex treatment regimen and the withdrawal of a social grant resulted in a lack of adherence for Neville. A pattern of adherence that was good for five and a half months, then poor for a few weeks, resulted and is typical of people 'playing' with meds in an attempt to retain a social grant.

Neville was recorded as being adherent by the clinic.

Ophelia's Story (Non-adherent – Adherent)

The 'secretive' patient (skips two or three doses of medication per week every week)

Our *isi*Xhosa-speaking researcher first met Ophelia at her home having received prior permission to call via an outreach worker. Ophelia was a 41 year-old woman who lived with her boyfriend and her daughter in an informal settlement about 1km from one of the clinics. She was unemployed and had no income. Ophelia's older child lived away from home and had menial work but was not in a position to provide any financial assistance to her mother. Ophelia relied solely on food parcels from the local home-based care centre, and handouts from friends. She tested HIV-positive in 2007 and she had not disclosed her status to her partner because she believed him to be HIV-negative.

5 *For more on this see Nattrass (2004) 'Trading-off income and health: AIDS and the disability grant in South Africa'.*

She had also been successfully treated for TB.

When initially diagnosed, and before commencing ARVs, Ophelia suffered from *ibande* (shingles). She described severe symptoms including pain and 'itchiness on the inside' and was given painkillers, sleeping tablets and calamine lotion by the clinic, none of which eased her condition. She attended a traditional healer who gave her some *muti*, that she took in addition to her other medication, but the *muti* caused diarrhoea so she stopped taking it and has not returned to her traditional healer.

Ophelia was prescribed Bactrim and Vit Bco, for three months during the work-up period for ARVs. However, she left the jurisdiction of the clinic to attend to family matters in *emaXhoseni* (Eastern Cape rural areas) and because of this was deemed to be a risk for adherence on ARVs when started.

In an effort to convince the clinic to support her application for a disability grant, Ophelia threatened not to take her medication unless she 'got the pay'. Her grant was never processed due to a series of bureaucratic errors and Ophelia was particularly aggrieved that, despite a CD4 count of 4 (four) cells/μl, she still received no financial assistance from the state.

Once ARVs were initiated, side effects including nausea, vomiting and a rash were constant. She attributed this to taking medication on an empty stomach but said when she told the clinic she had no food they didn't care. At the time of our first meeting Ophelia had not taken her medication properly for the previous two months. This was in part due to the breakdown in her relationship with the clinic who publicly berated and humiliated her for not adhering to the treatment regimen pre-ARVs. She was angered by their apparent unwillingness or inability to help with the grant application. The nausea and vomiting she experienced also discouraged her from full adherence. In addition, in an effort to hide her status from her boyfriend, Ophelia kept her medication at the home of her older daughter and could not always get to her daughter's home to collect the medication as required

Understanding Ophelia

A number of factors impacted on Ophelia's adherence behaviour but her pattern of adherence was such that she missed/skipped her medication twice or three times per week.

The grant application system presented bureaucratic obstacles impossible for Ophelia to overcome without assistance. This assistance is often given by the clinic, but given the breakdown in her relationship with the clinic, such assistance was not forthcoming. A series of errors with the application (no doctor's stamp, a shortage of clinic letterheads, Ophelia's inability to provide a utility bill) prevented it from even being processed despite the fact that she was clearly eligible under all the necessary criteria to receive funds. Her resentment with this situation was such that, at one stage, she was partly

refusing to take her medication as a protest, although since she struggled to articulate this clearly her protest went unnoticed.

Publicly berating patients for non-attendance or poor adherence behaviour is a common occurrence in ART clinics. Our researchers have been present when patients have been shouted at and while clinic staff have conducted telephone conversations with patients, using their name and personal details, all within view/earshot of a full waiting room. Lack of attention to issues of confidentiality has also resulted in patient files being left open for other patients to see and, in one extreme case, a patient berated continuously for non-adherence because the clinic had confused her with someone else of the same name. The breakdown in trust and resulting poor relationships have a bearing on adherence as patients will often refuse to attend after such an incident, for fear of receiving another public rebuke. As one patient put it 'She tells me I will die... Just die! I know I'm going to die but sometimes I have a problem.'

Finally, the fear of disclosure to a partner, workmate or other family members often causes patients to skip their medication rather than take it in view of others. One of our participants skips his medication once a week, when working on a specific shift with what he considers a suspicious co-worker. Conscious of the rattle of medication in a plastic pillbox, many patients prefer to carry their pills in plastic bags or loose in their pockets rather than have their status 'betrayed' by rattling pillboxes. This often results in a degradation of the pills as they become dirty and/or chipped. In cramped living conditions it is difficult to have secrets from loved ones and Ophelia's decision to leave her medication elsewhere in order to maintain some confidentiality had an enormous bearing on her health.

Ophelia was originally reported as 'non-adherent' but, still only on a partial usage schedule, she was, by the end of our research, recorded as 'adherent' by the clinic.

The Membrane Between the Clinic and the Community

At one level, these four cases add to a well-established record in the literature on HIV and ART concerning the unhappy alchemy of how resource scarcity, different expectations of the clinical encounter, a conflicted political history, and ways that various elements (both physical and human) structure how patients come to therapy (as well as the expectations people have of this treatment) in local moral worlds. Once on medication, however, studies on the temporality of ART adherence tend to bifurcate, with those in the Global North, largely stressing the psychotherapeutic aspects of choice, such as 'choosing life' (Gray 2006:52) or 'sticking to it' (Burton and Hudson 2001) or treating the co-morbid mental illness that interferes with decision-making (Daughters et al. 2010). In the Global South, on the other hand, the challenges in front of adherence as a process still (understandably) tend to be situated in political economic constraints and how brutal limitations impact

local notions of agency (for a review, see Brandt 2009; see also Siu et al. 2013 and Ezekiel et al. 2009 among many others). Despite long-standing calls (and even announcements) to combine such approaches (e.g., Parker 2001) in HIV research, in the Global North the internal psychic economy is seen to be decisive in ART adherence and, in the South, it is generally the ways that the straitened material economy or the local cultural topography of gender and class inhibits choice. In neither body of literature is the temporality of adherence to ART granted a decisive role in theory. Thus, while we have in Anthropology strong critiques of abstract choice, there is still a hesitation to explore agency as a processional phenomenon that emerges (and alters) over time in concrete social-historical circumstances (for a considered exception to this statement, see Irving 2011).

The fluidity of these categories, of course, has real-world consequences for our understanding of ART. In these four cases, for example, at the beginning of our research Benjamin and Neville were recorded as 'adherent' but within two years Benjamin was 'lost to follow-up' (even though we and the care-workers knew where he was in a geographic sense), and he subsequently died. Meanwhile, Neville remained 'adherent' although his use of medication was less than ideal. Gabriella and Ophelia on the other hand, both went (in the view of the clinic) from 'non-adherent' to 'adherent' even though they presented quite different patterns of consistently partial use. Whatever else these observations demonstrate they show that neither 'access' nor 'adherence' is a state, something that someone has/does not have or is/is not doing.

Instead, adherence is negotiated continuously, sometimes on a week-to-week basis – very often on grounds in-between 'medical' and 'non-medical' considerations, such as understandings of how 'healthy' one can be while still maintaining access to the social grant available to patients who are too sick to work. In many settings in our fieldwork, for example, real unemployment rates are in excess of 80%, thus the 'supplemental' income provided by the government for some HIV sufferers represents a significant improvement in household budgets. In the end, the picture that emerges is one in which HIV-positive individuals are often listed as 'adherent' when they are in fact experimenting with different schedules of ARVs, often while using complementary therapies in order to survive in circumstances that can be very close to overwhelming. At the same time, many of the 'non-adherent' (and even some of those who are ostensibly 'lost to follow-up') are still taking a significant amount of ARV medication.

There is of course a significant global risk in the widespread, but inconsistent, use of ARVs; that is the potential emergence of super-resistant strain(s) of HIV, something that could conceivably set the clock back to the early 1990s, or even the 1980s, for everybody.[6] While we do not wish to underplay the extraordinary success of the South African scale-up of ART, even where there has been the most dedicated staffing and

6 *The introduction of fixed dose combination therapy in 2013 has been heralded as something that should assist with adherence, but we note that very few people with whom we interacted found the schedule of the drugs per se to be a significant barrier to adhering to their treatment regimen. If scheduling as such is decisive, however, then we would predict an even higher failure rate on second-line treatment.*

monitoring - such as the work of Boulle et al. in Khayelitsha - about 10% have been lost to follow-up and over 14% are on second-line therapy because of adherence issues with their first-line drugs (Boulle et al 2010). The Western Cape in the Republic of South Africa, while a resource-poor setting, is probably the most 'developed' infrastructure for HIV treatment on the continent: it is where most of the assumptions about 'adherence', birthed in the industrial economies of the North (shaky as they may be for marginal populations in those settings) should best work. It is very hard to understand how we continue to track the success of programmes that in less than a decade scaled up a treatment regimen that serviced thousands (in very specific parts of the world) to one approaching ten million (delivered in nearly every part of the world) (UNAIDS 2013, WHO 2013), through these three simple categories - 'adherent', 'non-adherent' and 'lost to follow-up' - when the fluid nature of such categories are part of the tacit knowledge of most researchers and clinicians in this field.

Conclusion

Almost two decades after Farmer's clarion call to understand, 'the degree to which patients are able to comply with treatment regimens is significantly limited by forces that are simply beyond their control' (2001 [1999]), researchers in Global Health, International Health, Medical Anthropology, and beyond have recognized that structural violence imposes brutal limitations on a notional standard average subject making rational choices to take their meds and get better. Indeed, the term 'structural violence' has been absorbed into the working lexicon of practically all researchers in HIV and AIDS. Yet, after undeniable progress in tackling the plagues that were 'new' in the 1980s and 1990s, we find subjects and local moral worlds that are still resistant to easy comprehension or straightforward manipulation. To put it in perhaps more provocative terms: humans strive to regain (or help others regain) health, but not just as healers and sufferers please, and certainly not at a time and place of their own choosing. Resource scarcity and structural violence impacts individuals, families, and communities simultaneously but often in very different ways, even within the same neighbourhood. If treatment comes with an income supplement, for example, then its 'success' results not only in a now-healthier individual, but also in renewed distress of a family unit, even as a reinvigorated body emerges into a new horizon of local possibilities and limitations (see Mfecane 2012). In a similar fashion, powerful drugs enter local moral worlds at a particular historical moment, bearing specific valences. In South Africa, as in most of the Southern roll-out of ART, they often come coded as gifts with all the social-building and social-imperilling qualities that this term entails. They also confront indigenous forms of pharmacological reasoning that are only crudely labelled 'folk' and 'traditional', often with unforeseen results (see Larkan, van Wyk and Saris 2010). Yet, in the compiling of

'hard' data to measure 'success' and 'sustainability' such complex processes are recoded as discrete events, and significant decisions about programmes and populations ride on how these 'moments' are tabulated and analysed. As Biehl (2007:385) notes, "Numbers and statistics are intensely political," but the politics involved change over time and vary with the scale of the analysis. While this issue of the production of evidence has exercised scholars in Global Health for some time (see among many others, Pisani 2009 and Kleinman et al. 2008), we feel that the explosive expansion, the life-long nature, and the high individual and population costs of failure of ART all argue that this perspective needs to be more centrally positioned in longer-term ethnographic research on 'adherence'.

In making this case, we have no desire to further remove HIV treatment from the rest of any health system in resource-poor settings; indeed we are arguing the opposite. Both Harries et al (2006) and Bax et al. (2015), for example, convey some of the complexities of scaling up ART in resource poor settings, highlighting the need to ensure that other health services do not suffer in the attempts to improve HIV treatment. It is clearly health *systems* that need investment and overall strengthening. This insight is becoming obvious in the renewed Global Health/International Health interest in the immense burden of chronic and non-communicable diseases in resource poor settings (e.g., Alwan 2010). This insight, though, should be more expressly connected with a large literature on how issues of governmentality and long-term connection with medication and/or repeat clinical visits exist in other contexts (Leonard, Greene and Erbelding 2007, Saris 2008 and Montoya 2011, among many others). We would like to see the problem of ART adherence centrally positioned in this reinvigorated appreciation of health systems. In a sense, this call harkens back to themes in Critical Medical Anthropology that never went away (see Baer, Singer and Susser 2013 [1993]), but now we now confront the remarkable (if still partial) success of sheer access to drugs, and the reality of the immense diversity of the complex social-moral worlds into which these pharmaceuticals have been woven on an unprecedented scale.

To keep on top of this challenge, we will need to know a lot about a lot of things all at once – how people understand access to ART; but also much more precisely how they are taking their medication on a day-to-day through year-to-year basis, and, importantly, how they are monitored, especially, the specific mechanisms through which this knowledge is tabulated and disseminated. We will want to know about health services and health messages (and how to improve them), but we will also need to know how certain social-medical issues like how alcohol exist in extremely complex ways in historical memory and local moral worlds (see Mfecane 2011). We want to improve data-collection and analysis of health systems, but we need to understand the complexities of translation between communities of speech, language, class, and professional expertise (see Wood and Lambert 2008), as well as how this data is tabulated and scaled up in as fine-grained a way as is feasible. Most importantly, we need to do this rigorously and consistently

over long periods of time. This is precisely the sort of knowledge good, long-term ethnographic work generates. Living with HIV means living with and on ART, and such therapeutic citizenship is no less conflicted and ambivalent as 'citizenship' in any other collectivity. We require many more researchers who track between the people producing such categories of inclusion and exclusion and those who inhabit them (sometimes all of them) at very different scales and at different moments in time. Such work is necessary both to safeguard the enormous gains that have been made in the past decade or so and to protect against an unseen and unappreciated global experiment where potentially millions of bodies with sub-optimal ART unnecessarily (and in a public health sense, very dangerously) sicken with resistant new sub-types of the virus. It is also a critical piece in the puzzle to better understand how the three clean bureaucratic categories of 'adherent', 'non-adherent', and 'lost to follow-up' ultimately fit the complex biosocial realities that we wish to both analyse and improve.

References

Abel, E. and Painter L. (2003) Factors that Influence Adherence to HIV Medications: Perceptions of Women and Health Care Providers. *Journal of the Association of Nurses in Aids Care.* 14(4) 61-69.

Alwan, A. Global status report on noncommunicable diseases 2010. WHO. http://whqlibdoc.who.int/publications/2011/9789240686458_eng.pdf

Ammassari, A., Antinori, A., Aloisi, M.S., Trotta, M.P., Murri, R., Bartoli, L., D'Arminio Monforte, A., Wu, A., Starace, F. (2004). Depressive Symptoms, Neurocognitive Impairment, and Adherence to Highly Active Antiretroviral Therapy Among HIV-Infected Persons. *Psychosomatics*. 45(5) 394-402.

Baer, H. A., M. Singer and I Susser. (2013 [1993]) Medical Anthropology and the World System: Critical Perspectives, Third Edition. Santa Barbara, CA: Praeger.

Bam, K., Rajesh M Rajbhandari, Dibesh B Karmacharya and Sameer M Dixit. (2015) Strengthening adherence to Anti Retroviral Therapy (ART) monitoring and support: operation research to identify barriers and facilitators in Nepal. Health Services Research. 15:188.

Bardel A., Wallander M., Svarsdsudd, K. (2007). Factors associated with adherence to drug therapy: a population-based study. European Journal of Clinical Pharmacology, 63: 307-314

Battaglioli-DeNero, A. (2007). Strategies for Improving Patient Adherence to Therapy and Long-Term Patient Outcomes. *Journal of the Association of Nurses in AIDS Care*. 18(15) S17-S22.

Biehl, J. (with photographs by T. Eskerod). (2007). Will to Live: AIDS Therapies and the Politics of Survival.

Boulle A., Van Cutsem G., Hilderbrand, K. Cragg. C., Abrahams M., Mathee S., Ford N., Knigh L., Osler M., Myers, J., Goemaere E., Coetzee D., and Maartens, G. (2010). Seven Yeards Experience of a Primary Care Antiretroviral Treatment Programme in Khaylitsha, South Africa. AIDS 24:563-572.

Brandt R. (2009) The Mental Health of People Living with HIV/AIDS in Africa: A Systematic review. African Journal of AIDS Research. 8:2:123-133. [accessed on 4 June 2014]

Bruera, E. (2006). The Political Economiy of Antiretroviral Drugs. *CSSR Working Paper No. 179*. http://www.cssr.uct.ac.za/sites/cssr.uct.ac.za/files/pubs/wp179.pdf [accessed 11.02.2015]

Burton, R. P. D., & Hudson, T. (2001). Achieving individually sustained commitment to treatment through self-constructed models of medical adherence. Sociological Spectrum, 21, 393-422.

Conen, A., Fehr, J., Glass, T.R., Furrer, H., Weber, R., Vernazza, P., Hirschel, B., Cavassini, M., Bernasconi, E., Bucher, H.C. & Battega, M. (2009). Self-reported alcohol consumption and its association with adherence and outcome of antiretroviral therapy in the Swiss HIV Cohort Study. *Antiviral Therapy*, 14: 349-357.

Crespo-Fierro, M. (1997). Compliance/Adherence and Care Management in HIV Disease. *Journal of the Association of Nurses in AIDS Care.* 8(4) 43-54.

Daughters S., Magidson J., Schuster R., and Safren S. ACT Health: Combined Cognitive-Behavioral Depression and Medication Adherence Treatment for HIV-Infected Substance Users. Cognitive and Behavioural Practice. 17:309-321. [accessed on 17 March 2015]

Deumert, A. (2010). 'It would be nice if they could give us more language' – Serving South Africa's multilingual patient base. *Social Science and Medicine.* 71, 53-61.

Donovan J., Blake D. (1992) Patient non-compliance: deviance or reasoned decision-making? *Social Science and Medicine*, 34:507-13.

Ezekiel, Mangi Job, Aud Telle, James M Juma, Knut-Inge Klepp (2009). "When in the Body, It Makes You Look Fat and HIV Negative: The Constitution of Antiretroviral Therapy in Local Discourse Among Youth in Kahe, Tanzania. *Social Science and Medicine*. 68(2009):957-964.

Farmer, P. (2001 [1999]) *Infections and Inequalities*. University of California Press: Berkeley.

Gallant, J. (2002). Initial therapy of HIV infection. *Journal of Clinical Virology*. 25, 317-333.

Gao X. Nau DP. Rosenbluth SA. Scott V. Woodward C. (2000). The relationship of disease severity, health beliefs and medication adherence among HIV patients. *AIDS Care.* 12:387–398.

Garcia, P., Cote, J. (2003) Factors Affecting Adherence to Antiretroviral Therapy in People Living with HIV/AIDS. *Journal of the Association of Nurses in AIDS Care,* 14(4): 37-45.

Gay, C., Portillo, C., Kelly, R., Coggins, T., Davis, H., Aouizerat, B., Pullinger, C., Lee, K. (2010). Self-Reported Medication Adherence and Symptom Experience in Adults with HIV. *Journal of the Association of Nurses in AIDS Care.* 22(4) 257-268.

Grant, E., Logie, D., Masura, M., Gorman, D., Murray, S. (2008). Factors facilitating and challenging access and adherence to antiretroviral therapy in a township in the Zambian Copperbelt: a qualitative study. *AIDS Care* 20(10) 1155-1160.

Gray, J. (2006). Becoming Adherent: Experiences of Persons Living with HIV/AIDS. *Journal of the Association of Nurses in AIDS Care*. 17(3) 47-54.

Guion, L., Diehl, D., McDonald, D. (2011). Triangulation: Establishing the Validity of Qualitative Studies. *University of Florida, IFAS Extension. http://www.ie.ufrj.br/hpp/intranet/pdfs/texto_7_-_aulas_6_e_7.pdf* [accessed 6.2.2015]

Hardon AP, Akurut D, Comoro C, Ekezie C, Irunde HF, Gerrits T. (2007). Hunger, waiting time and transport costs: Time to confront challenges to ART adherence in Africa. *AIDS Care*, 19(5): 658-665

Hargie, O., Morrow, N., Woodman, C. (1999). Pharmacists evaluation of key communication skills in practice. *Patient Education and Counselling.* 39, 61-70.

Harries, D., Schouten, E., Libamba, E. (2006). Scaling up antiretroviral treatment in resource-poor settings. *The Lancet.* 367; 1870-1872.

Hubbard M. (2006) Dealing with obstacles in adhering to Highly Active Antiretroviral Therapy. Journal of the Association of Nurses in AIDS Care, 17(1): 18-25

Ingersoll, K., Cohen, J. (2008). The impact of medication regimen factors on adherence to chronic treatment: a review of literature. *Journal of Behavioural Medicine*, 31: 213-224.

Irving, A. (2011) Strange Distance: Towards an Anthropology of Interior Dialogue. *MAQ*, Vol. 25, Issue 1, pp. 22–44.

Kaijee, L. and Beardsley, R. (1992). Pscyhotropic Drugs and Concepts of Compliance in a Rural Mental Health Clinic. *Medical Anthropology Quarterly,* 6(3): 271-287.

Kalichman, S., Cherry, J., Cain, D. (2005). Nurse-delivered Antiretroviral Treatment Adherence Intervention for People with Low Literacy Skills and Living With HIV/AIDS. *Journal of the Association of Nurses in AIDS Care.* 16(5) 3-15.

Katzenstein, D., (1997). Adherence as a Particular Issue with Protease Inhibitors. *Journal of the Association of Nurses in AIDS Care.* 8, 10-17.

Larkan, F., Van Wyk, B., and Saris, AJ (2010). Of Remedies and Poisons: Recreational Use of Antiretroviral Drugs in the Social Imagination of South African Carers. *African Sociological Review,* 14 (2) 62-73.

Leonard, L., J. L. Greene, E. Erbelding. (2007) Persons, Places, and Times: The Meanings of Repetition in an STD Clinic. MAQ. Vol. 21, Issue 2, pp. 154–168.

Libby, A., Fish, D., Hosokawa, P., Linnebur, A., Metz, K., Nair, K., Saseen, J., Griend, J., Vu, S., Hirsch, J. (2013). Patient-Level Medication Regimen Complexity Across Populations With Chronic Disease. *Clinical Therapeutics*. 35(4) 385-398

Lima, V., Fernandes, K., Rachlis, B., Druyts, E., Montaner, J., Hogg, R. (2008). Migration adversely affects antiretroviral adherence in a population-based cohort of HIV/AIDS patients. *Social Science & Medicine* 68, 1044-1049.

London, L. (2000). Alcohol consumption amongst South African farm workers: a challenge for post-apartheid health sector transformation. *Drug Alcohol Depend; 59(2) 199-206.*

Maskovsky, J. (2005). Do People Fail Drugs, or Do Drugs Fail People?: The Discourse of Adherence. *Transforming Anthropology,* 13(2) 136-142.

Mattes, D. (2012). "I am also a Human Being!": Antiretroviral Treatment in Local Moral Worlds. Anthropology & Medicine. 19(1):79-84. [accessed on 3 February 2014].

McKinstry, J. (2005) Using the Past to Step Forward: Fetal Alcohol Syndrome in the Western Cape Province of South Africa. *American Journal of Public Health;* 95(7) 1097-1099.

Mfecane, S. (2012). Narratives of HIV disclosure and masculinity in a South African village, Culture, Health & Sexuality. 2012:1-13 http://dx.doi.org/10.1080/13691058.2011.647081 [accessed 16 June 2015]

Mfecane, S. (2011) To drink or not to drink? Identity dilemmas of men living with HIV, Agenda: Empowering women for gender equity, 25:4, 8-17. http://dx.doi.org/10.1080/10130950.2011.630520 [accessed 16 June 2015]

Mills, E. (2008) 'Swimming in Confusion': A Qualitative Appraisal of Factors Affecting Uptake and Adherence to Antiretroviral Treatment in South Africa. CSSR Working Paper no. 208. http://www.cssr.uct.ac.za/publications/working-paper/2008/swimming-confusion-qualitative-appraisal-factors [accessed 11.02.2015]

Mitchell, G., and Linsk, N. (2004). A Multidimensional Conceptual Framework for Understanding HIV/AIDS as a Chronic Long-Term Illness. *Social Work,* 49(3) 469-477.

Montoya, M. (2011) Making the Mexican Diabetic: Race, Science and the Genetics of Inequality. Berkeley: University of California Press.

Murray, L., Semrau, K., McCurley, E., Thea, D., Scott, N., Mwiya, M., Kankasa, C., Bass, J., Bolton, P. (2009). Barriers to acceptance and adherence of antiretroviral therapy in urban Zambian women: a qualitative study. *AIDS Care* 21(2) 78-86.

Naimak, TH. (2006). Antiretroviral treatment in the western cape: a success story facilitated by the global fund, *Centre for Social Science Research, Aids and Society Research unit working paper No.161*,

Nam, S., Fielding, K., Avalos, A., Dickinson, D., Gaolathe, T., Geissler, P. (2008). The relationship of acceptance or denial of HIV-status to antiretroviral adherence among adult HIV patients in urban Botswana. *Social Science and Medicine,* 67: 301-310.

Nattrass, N. (2004). Trading-Off Income and Health: AIDS And the Disability Grant in South Africa. CSSR Working Paper no. 82 http://cssr.uct.ac.za/sites/cssr.uct.ac.za/files/pubs/wp82.pdf [accessed 11.02.2015]

Nattrass, N. (2008). The (political) economics of antiretroviral treatment in developing countries. *Trends in Microbiology,* 16(12) 574-579.

Olivier, L., Urban, M., Temmerman, M., Viljoen, D. (2013). Burden of fetal alcohol syndrome in a rural West Coast area of South Africa. *South African Medical Journal;* 103(6).

Parker, R. (2001). Sexuality, Culture and Power in HIV/AIDS Research. Annual Review of Anthropology. 30:163-179.

Passani

Penn, C., Watermeyer, J., Evans, E. (2011). Why don't patients take their drugs? The role of communication, context and culture in patient adherence and the work of the pharmacist in HIV/AIDS. *Patient Education and Counseling,* 83, 310-318.

Reif, S., Golin, C.E. & Smith, S.R. (2005). Barriers to accessing HIV/AIDS care in North Carolina: rural and urban differences. *AIDS Care*, 17(5): 558-565.

Russell, Steven and Janet Seeley (2010). The Transition to Living with HIV as a Chronic Condition in Rural Uganda: Working to Create Order and Control on Antiretroviral Therapy. *Social Science and Medicine*. 70(2010):375-382.

Saris, AJ., Larkan, F., Van Wyk, B., Stevens, P. and Ramela, T. (2012) *Understanding Barriers to Access and Adherence to Antiretroviral Treatment in South Africa's Western Cape Province.* Final Report submitted to Health Research Board, Dublin, Ireland, 41pp.

Saris, A. Jamie 2008 "An Uncertain Dominion: Irish Psychiatry, Methadone, and the Treatment of Opiate Abuse." Special Edition of *Culture, Medicine, and Psychiatry* (Dominique Behague, Guest Editor) 32(2):239-257. http://eprints.nuim.ie/1125/

South African Department of Health Annual Report 2013-2014. http://www.gov.za/sites/www.gov.za/files/Department_of_Health_Annual_Report_2014.pdf [accessed 13.02.2015]

South African Department of Health. (2014). National Consolidated Guidelines for the Prevention of Mother-toChild Transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults. Available at http://www.sahivsoc.org/upload/documents/HIV guidelines _Jan 2015.pdf [accessed 13.02.2015]

Shah, C.A. (2007) 'Adherence to High Activity Antiretroviral Therapy (HAART) in pediatric patients infected with HIIV: Issues and interventions'. *Indian Journal of Pediatrics.* 74(1): 50-60.

Siu G., Seeley J., and Wight, D. (2013). Dividuality, Masculine Respectability and Reputation: How Masculinity Affects Men's Uptake of HIV Treatment in Rural Eastern Uganda. Social Science & Medicin. 89(2013):45-52 [Accessed 2 February 2015]

Spire, B., Duran, S., Souville, M., Leport, C., Raffii, F., Moatti, J. P., et al. (2002). Adherence to highly active antiretroviral therapies (HAART) in HIV-infected patients: From a predictive to a dynamic approach. Social Science and Medicine, 54, 1481-1496.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage.

Tugenberg, T., Ware, N., Wyatt, M. (2006). Paradoxical Effects of Clinician Emphasis on Adherence to Combination Antiretroviral Therapy for HIV/AIDS. *AIDS Patient Care and STDs*, 20(4) 269-274.

Tuller, D.M., Bangsberg, D.R., Senkungu, J., Ware, N.C., Emenyonu, N. & Weiser, S.D. (2010) Transportation costs impede sustained adherence and access to HAART in a clinic population in Southwestern Uganda: a qualitative study. *AIDS Behaviour*, 14: 778-784.

UNAIDS (2012) Report on the Global AIDS Epidemic. http://www.unaids.org/sites/default/files/media_asset/20121120_UNAIDS_Global_Report_2012_with_annexes_en_1.pdf [accessed 06 February 2015]

UNAIDS (2013) Global Report: UNAIDS Report on the Global AIDS Epidemic. http://www.unaids.org/en/resources/documents/2013/20130923_UNAIDS_Global_Report_2013 [accessed 06 February 2015]

Watermeyer, J., Penn, C. (2008) "Tell me so I know you understand": Pharmacists' verification of patients' comprehension of antiretroviral dosage instructions in a cross-cultural context. *Patient Education and Counseling,* 75, 205-213.

Western Cape Government DoH Annual Performance Plan 2011/2012 available from http://www.westerncape.gov.za/other/2011/3/health_app_2011_2012.pdf [accessed on 04 April 2012]

Western Cape Government DoH Annual Report 2013/2014 available from http://www.westerncape.gov.za/sites/www.westerncape.gov.za/files/wcgdh14_annual_report_full_small.pdf [accessed 13.02.2015]

Wood, K. and H. Lambert. (2008) Coded Talk, Scripted Omissions: The Micropolitics of AIDS Talk in an Affected Community in South Africa. MAQ. Vol. 22, Issue 3, pp. 213–233.

World Health Organisation (2003). Adherence to long-term therapies: evidence for action http://www.who.int/chp/knowledge/publications/adherence_report/en/index.html [accessed on 04 November 2009]

World Health Organisation (2013) Global update on HIV treatment 2013: Results, Impact and Opportunities http://apps.who.int/iris/bitstream/10665/85326/1/9789241505734_eng.pdf?ua=1 [accessed 06 February 2015]

Holistic Development: Muslim Women's Civil Society Groups in Nigeria, Ghana and Tanzania

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Abstract

Muslim women's organizations in East and West Africa have cultivated successful strategies to mitigate the varied domestic economic and political outcomes produced by globalization. Although China and the BRICS countries are providing multipolar development models their results may not differ significantly from their western counterparts if groups that are often left out of the decision-making processes are not included. There is an urgent need for social scientists to make the experiences of African women as designers of development the central point of theorizing in order to inform how we conceptualize economic and political participation and measure inequality. This paper will utilize case studies from local women's non-governmental and community based organizations in Kano, Nigeria, Tamale, Ghana and Dar es Salaam, Tanzania to help develop mechanisms for sustainable economic growth and substantive representation, which I argue, can help generate state institutions that are more responsive to the needs of their citizens. Mainstreaming gender, as an analytical frame is essential because it interrogates privilege, illustrates how it is distributed among and between women and men and provides insights into partnerships that can be forged across genders. Furthermore, the institutional linkages of women's organizations both within and across national contexts strengthens the ability of African countries to look internally and share their development best practices through sub- regional entities and the African Union. Finally, civil society needs to be redefined and contextualized using the perspectives of citizens at the grassroots level to produce holistic policy recommendations for all three tiers of governance (domestic, sub-regional and regional).
Keywords: *African women, muslim women, civil society, economic development, sustainable growth, governance*

Résumé

Les organisations de femmes musulmanes en Afrique orientale et occidentale ont cultivé des stratégies efficaces pour atténuer les résultats économiques et politiques intérieures variées produites par la mondialisation. Bien que la Chine et les pays du BRICS fournissent des

modèles de développement multipolaires leurs résultats peuvent ne pas différer sensiblement de leurs homologues occidentaux si les groupes qui sont souvent exclues des processus de prise de décision ne sont pas inclus. Il ya un besoin urgent pour les scientifiques sociaux de faire l'expérience des femmes africaines en tant que concepteurs de développement le point central de la théorisation afin d'informer notre façon de conceptualiser la participation économique et politique et mesurer les inégalités. Ce document utilisera des études d'organisations non-gouvernementales et communautaires locales de femmes à Kano, au Nigeria, Tamale, au Ghana et Dar es-Salaam, en Tanzanie cas pour aider à développer les mécanismes pour une croissance économique durable et de la représentation de fond, qui je soutiens, peut aider à générer Etat institutions qui sont plus sensibles aux besoins de leurs citoyens. Intégrer le genre, comme un cadre d'analyse est essentielle car elle interroge privilège, illustre comment il est distribué parmi et entre les femmes et les hommes et donne un aperçu des partenariats qui peuvent être forgées à travers sexes. En outre, les liens institutionnels des organisations de femmes, tant au sein des contextes nationaux renforce la capacité des pays africains à regarder à l'intérieur et à partager leurs meilleures pratiques de développement à travers des entités sous-régionales et l'Union africaine. Enfin, la société civile doit être redéfini et contextualisée en utilisant les points de vue des citoyens au niveau local pour produire des recommandations de politiques globales pour les trois niveaux de gouvernance

***Mots-clés: f**emmes africaines , les femmes musulmanes , de la société civile , le développement économique, la croissance durable, la gouvernance*

Introduction

Over the last two decades Muslim women's civil society organizations (CSOs) in Africa have become increasingly more engaged in development work specifically in the areas of gender equality, economic inequality, education, health and political participation. Local Muslim women's organizations in East and West Africa have cultivated successful strategies to mitigate the varied domestic economic and political outcomes produced by globalization. By placing women at the center of economic production they become the designers of development rather than being designated as the recipients of development programs. Additionally, the women's organizations that were the focus of this study further illustrate the importance of being able to create independent and new constructs of development that are contextualized within national contexts and communities. More specifically these CSO's including non-governmental (NGOs) and community based organizations (CBOs) also focus on addressing the needs of groups that are often excluded from decision making in particular women. Finally these CSOs work with a cross section of women ensuring that privileged voices are not the sole shapers of development narratives and programming suggestions (Wallace 2014). The strategies of Muslim women's groups illustrate that it is possible to devise sustainable mechanisms of economic,

social and political inclusion while challenging the current international development paradigms. Although China and the BRICS countries have the potential to provide multipolar development models their results may not differ significantly from their western counterparts if groups that are often left out of the decision-making processes i.e. local Muslim women's organizations are not included.

There have been several critiques of development approaches defined by the Washington Consensus which tend to 1) prioritize economic growth using purely quantitative measures, 2) create definitions of development and associated metrics based on the perspectives of western countries, and 3) rely on neoliberal models which can serve to inculcate vulnerable populations into global economic systems of governance (Mkandawire 2014; Mama 2001; Adedeji 2004; Cornwall 2003). Furthermore, groups such as Fifty Years is Enough and others critique the ineffectiveness of the current neoliberal development models arguing that the WB, IMF, USAID and others have failed to attain their articulated economic and social goals. There is a long tradition of African scholars that have criticized normative development models (Mkandawire 2014; Mama 1996, 2001; Adedeji 2004; Imam 1997). Dambisya Moyo in her work Dead Aid further contextualized these problems highlighting the fact that after almost one trillion in aid dollars traveling from western countries to Africa the average citizens on the continent are less economically secure and inequality persists as a result of growth rates that are unsustainable (Moyo 2009). Additionally Moyo touts the aid cycle as one of the key reasons low growth rates persist, corruption continues and local markets tend to atrophy. She instead suggests that providing more foreign direct investment in the form of capital flows to governments, which can in turn make funds available to entrepreneurs in African countries, will create a stronger domestic private sector, sustainable growth and a more equitable distribution of revenue (2009).

Moyo's critique is critically important to our understandings of the relationship between FDI and development aid as it is currently implemented and financed. I would argue further that cultivating a robust domestic private sector also requires that all stakeholders including women who often comprise a significant portion of small scale local vendors, etc. are included in the discussions regarding how to distribute and access capital. These factors are critically important and groups that are economically marginal are often not part of the process. While economic independence through investment rather than dependence on aid is ideal model Moyo's solution subverts the instruments of global governance present in international development organizations yet promotes neoliberalism in her efforts to use external FDI to generate growth the private sector. It is important to note that the economic contributions that women make through the domestic labor, wage employment, and volunteer work are often not included in aggregate economic data (Kabeer 2005). More specifically their development work is similarly overlooked (Wallace 2014). Their contributions through NGOs and CBOs should be viewed as a central component of development however it is important to

recognize that their significance can be undermined if local women's organizations are unable to mitigate the influences that international development groups often wield in shaping development discourses and policies.

Several feminist works have explored the relationship between domestic women's organizations and international donors in detail. Microcredit in particular which has often been touted as a way for women to involved in small scale trading and other activities can increase their profit margins in addition to securing financial stability. The Gareem bank in particular is often hailed as an example of the success of these models. Feminist scholars have explored the ways in which microcredit can be problematic for women who are often most economically vulnerable because they also use the same neoliberal modes of economic development to has been analyzed. For example, Christine Keating, Claire Rasmussen, and Pooja Rishi (2010) disrupt narratives of microcredit that claim to enhance women's economic status and thereby increase their political and economic bargaining power. While their critiques are important, it is, at the same time, problematic to assume that local NGOs invariably integrate women into the neoliberal economic systems in ways that make them additionally vulnerable. Local Muslim organizations, which are the focus of this study, rely on multiple sources of domestic funding are therefore often able to avoid participation in neoliberal models of microcredit provision (Wallace 2014).

There is an urgent need for social scientists to make the experiences of African women as designers of development the central point of theorizing in order to inform how we conceptualize economic and political participation and measure inequality. This paper will utilize case studies from local women's NGOs and CBOs in Kano, Nigeria, Tamale, Ghana and Dar es Salaam, Tanzania to help develop mechanisms for sustainable economic growth and substantive representation, which I argue, can help generate state and regional institutions that are more responsive to the needs of their citizens. Mainstreaming gender, as an analytical frame is essential because it interrogates privilege, illustrates how it is distributed among and between women and men and provides insights into partnerships that can be forged across genders. Furthermore, the institutional linkages of women's local organizations both within and across national contexts strengthens the ability of African countries to look internally and share their development best practices through sub-regional entities and the African Union. Finally, civil society needs to be redefined and contextualized using the perspectives of citizens at the grassroots level to produce holistic policy recommendations for all three tiers of governance (domestic, sub-regional and regional).

Methods

This paper captured the experiences of Muslim women's local civil society organizations (NGOs and CBOs) groups in Kano, Nigeria, Tamale, Ghana and Dar es Salaam, Tanzania to illustrate their ability to define develop and establish mechanisms for sustainable economic growth and substantive representation, which I argue can help generate state, sub-regional, and regional institutions that are more responsive to the needs of their citizens. This is critically important as Africa as a region continues to engage with the BRICS to address development goals. I drew primarily on feminist and interpretivist ethnographic methods to create a textured picture of the dynamics and interactions among women and between women and the state (Martha MacDonald 1995; Barbara Callaway1987; Gwendolyn Mikell 1997; Sherryl Kleinmon 2007, Richa Nager and Susan Geiger 2007; Jan Kubik 2009). By centering the experiences of Muslim women I was able to utilize their perspectives to speak back to the existing statistical data on labor and policy prescriptions for development and women generated by the state. This approach provided empirical data about women's economic and political activities and revealed gaps present in quantitative data on the economic and political contributions of Hausa women (Renne Pittin 1991; Mama 1996). Using qualitative research methods across disciplinary boundaries helps redress data limitations (McDonald 1995; Petra Debusscher and Anna Vleuten 2012). In the field, I opted to maximize rich descriptions of the activities and perspectives of a representative cross section of NGOs, CBOs, and Muslim women.

My methodological approach also allows me to showcase the agency and perspectives of Muslim women including how they define development, how they situate their work within the context of Islam, and their mobilization strategies around gender which at times includes engaging political structures. Three key factors are captured: 1) maintaining autonomy through funding strategies, 2) creating an inclusive approach to development cutting across social locations, 3) utilizing religion and cultural identities toward contextualizing development goals. Using a mixed methods approach including semi-structured interviews (Leech 2003) provides insights into the ways in which gender and production roles are linked to and vary from prescribed development goals – as I elaborate below.

The groups that have been the focus of this study are local Muslim women's organizations where the leadership is not economically dependent on the revenue from the group for their economic security. This coupled with their multiple streams of funding spanning domestic and international and local community and religious leaders sources allow them to be discerning about which partners they work with on which projects thereby preventing their vitality from being externally dependent or susceptible to grant cycle shocks and to remain viable during programming cycles (Wallace 2014). The CSOs that were selected for this study are as follows:

I focused on two NGOs in Kano, Nigeria to illustrate their ability to advance diverse sets of policy interests exemplified by the Federation of Muslim Women's Associations in Nigeria's (FOMWAN) work on the maternal health bill and the emphasis on making grassroots women the primary accountability partners for the local ministry of health's delivery of goods and services which the Grassroots Health Organization of Nigeria (GHON) facilitated during the programs they conducted in four local government areas to increase the access of local communities to health care facilities. These organizations 1)

focus on development issues, 2) assist vulnerable populations, and 3) have connections with community-based organizations. FOMWAN is a membership group including CBOs.

I relied on participant observation to analyze how the women in these organizations related to one another, for example at programs conducted by GHON, the primary focus of this study, as well as their NGO and CBO networks. I observed the first initiative focused on increasing access to health care facilities of communities in four local government areas (LGAs) conducted in partnership with Pact Nigeria and the Kano State Ministry of Health, which was funded by the Nigerian government. Observing GHON, given the breadth of its development work and the different women that come together through the organization, revealed the ways in which privilege is constructed and contested by Hausa women and the variety of ways in which they conceptualize development on their own terms.

In Tamale, Ghana, I observed Enterprising Women in Development (EWID) an NGO that focuses on advocacy in health, policy, politics and development for women. The executive director is also the head of the Federal Organization of Muslim Women in Ghana (FOMWAG). FOMWAG is a national association for Muslim women. Much of their work centers on hosting workshops that inform Muslim women about critical issues and policy developments that will impact them. Finally I interviewed one of the members of the elders council of women cooperatives in the Hausa zongo community. The women of the zongo have formed a series of trading cooperatives in order to support each other and increase profits. Islam plays a central role in the lives of each participant with particular emphasis on being self-sufficient in their different capacities.

Sahiba Sisters is the organization that I selected to focus on in Tanzania given that it is independent from the state in contrast to the Tanzanian Muslim Council (BAKWATA). The BAKWATA tends to be overrepresented in the literature (Tripp 2012). Sahiba Sisters serves as an umbrella organization for over forty-eight local Muslim women's NGOs and CBOs that are often unregistered. Sahiba Sisters perates in thirteen regions in Tanzania including Mwanza, Manyara, Morogoro, Dodoma, Iringa, Mbeya, Kilimanjaro, Dar es Salaam, Lindi Town, Tabora, Kigoma, Songea, Zanzibar (Unguja and Pemba). Accessing the perspectives of these women's organizations is critical because they illustrate the interests and priorities of organizations that are often marginal to the state and the international development community.

Development For Whom?

The debate on how development is defined, who has the right to define it, and how attaining development goals is monitored and evaluated is extensive. Mkandawine's recent piece "The Spread of Economic Doctrines & Policy-making in Post Colonial Africa" provides key insights into the ideological assumptions implicit in economic development approaches in Africa (2014). He argues that the materialist approach to African development often reflects the foreign interests of western countries and the resulting policy frameworks emphasize socially constructing these materialist frames. Furthermore, his work chronicles the shift from the structuralist- developmentalist or neo-Marxist approach of the sixties and seventies, to the neoliberalism of the eighties and nineties, and the contemporary emphasis on growth and welfare through poverty reduction and income redistribution (Mkandawine 2014). He posits instead that of focusing on the interests of actors and institutional constraints that development theorists should prioritize the cultivation of ideas capable of "helping us understand any society" (Mkandawine 2014:179). In other words the key is being able to conceptualize the ways in which the intersections of the political, cultural, economic, social, and historical factors serve to shape societies within national contexts. Academics in particular are charged with this task given the influence that the scholarship we produce has on policy outcomes. In an effort to heed this call this work this paper will explore the ways local Muslim Women's organizations in East and West Africa have cultivated successful strategies to advance their own definition of development, work across lines of privilege, and mitigate the varied domestic economic and political outcomes produced by the globalization of development paradigms.

Development aid acquired from the World Bank, the International Monetary Fund, and other international donors is usually under the control of the state. Therefore, in many cases, the implementation of programs sourced with these funds can function as a form of global governance because they monitor and regulate women's economic activity. Consequently, the constraints imposed by donors have the potential to affect women – if women's organizations un-reflexively conduct programming By circumventing the international donor exclusivity they are able to mitigate the negative costs. (M.L. Campbell and Kathy Teghtsoonian 2010). In *Women's Studies and Studies of African Women During the 1990s* Amina Mama writes that economics tends to be built upon masuclinst distinctions between the formal and informal economy and the biological rather than social reproduction. Macroeconomic analysis is based on "maternal altruism" rendering women's economic contributions invisible. African women's labor invalidates the formal and informal binary because in many ways the income-generating activities are extensions of their domestic labor, posing an interesting critique of the public and private binary. Furthermore, the extensive trade networks and financial transactions that women engage in using the market dismantle the nuclear depiction of kinship networks. Mama raises some critical critiques of economics and state and society; however they need to be contextualized within the experiences of Muslim women in Nigeria, Ghana, and Tanzania.

Historically, the shifts in development paradigms from Women in Development (WID), to Women and Development (WAD), to Gender and Development (GAD) reflect the expansion of theoretical models to address structural impediments and attempt to attain gender equality through organizations (Eva Rathgeber 1999; Hedayat

Nikkhah, Ma'rof Redzuan, and Asnarulkhadi Abu-Samah 2012). NGOs transform individual levels of empowerment into collective efforts to challenge gendered power dynamics, and cultural and institutional constraints through programs and awareness campaigns (Vandana Desai 2005; Nikkhah et al 2012). Furthermore, these groups can function as sites to reconstitute new gender norms by mainstreaming concerns of women into development approaches and policies and increasing their presence in public spaces (Andrea Cornwall, Elizabeth Harrison, and Ann Whitehead 2004; Caroline Moser and Annalise Moser 2005; Mats Alvesson and Yvonne Billing 2009). While NGOs can potentially deconstruct gender hierarchies domestically, relationships between international and local organizations are also capable of re-inscribing privilege given differentials in the ability to influence development agendas (Kanchana Ruwanpura 2007). The level of impact of globalization and on domestic political and economic systems depends in many ways on the amount of inclusion women and other vulnerable groups have on decision making frames as they relate to national production goals and associated policy priorities. The Millennium Development goals showcase the importance of thinking about gender empowerment as "the ability to make choices" (Kabeer 2005). She elaborates further that it is essential to see gender equality and women's empowerment as "an intrinsic rather than an instrumental goal, explicitly valued as an end in itself rather than as an instrument for achieving other goals." (Kabeer 2005). In other words not only is it important that there are other options available but they also need to be visible and accessible in order for agency to be exercised.

The BRICS have the potential to incorporate the agency of excluded actors through the cultivation of a multipolar approach to development and consequently global governance which has been highlighted by several scholars (Armijo 2007; Glosny 2010; Gammeltoft 2008; Hau et al 2012; Purushothaman 2003). BRICS have generated new opportunities and forums for international engagement with other actors that are essential to both domestic and regional trends. More broadly the members of the BRICS focus on natural resources acquisition, expansion into new markets and identifying investment sectors in emerging markets (Hau et al 2012). The interaction with Africa is not based solely on economic interests. Instead the BRICS frame their relationship with Africa in the context of a mutual interest in being free from western exploitation and imperialism (Schoeman 2011). Brazil attempts to draw the connection along the cultural connections stemming from the legacies of the slave trade and India underscores their mutual colonial experiences with the UK (Schoeman 2011). Although there is potential, there are also ways in which the divergent national interests of member countries can serve to constrain bilateral relationships with Africa (Glosny 2010; Sharma 2012). They can emphasize trade on natural resources in the energy sector which comprise approximately 67% of exports to Nigeria, Angola, and Sudan (Schoeman 2011). In an effort to break out of this model Souza highlights Brazil's cooperation approach to development as a partnership with African countries including technical cooperation-knowledge and technology, humanitarian

cooperation via agriculture, and social development in health and education (2014). India has also attempted to branch out into health, education, information communication technology and automobiles (Kimenyi & Lewis 2011). The recent establishment of the BRICS development Bank and contingency fund illustrate that development is a key priority of the BRICS. It is therefore essential that the BRICS invite Muslim women's organizations to the table allowing them to utilize their institutional knowledge to help ensure that the BRICS new development bank does not repeat the same mistakes as the Washington Consensus models.

The development work of African Muslim women captures their agency in successfully resisting externally constructed definitions of Muslim women both by the men in their families and communities and by foreign development organizations (Oeronke Oyewumi 1998; Ayesha Imam 1997; Adamu 1999). Understanding how women are negotiating these tensions in their labor and mobilization choices and strategies, in addition to levels of institutionalization and affiliation provides direct evidence of women negotiating the "double edged" sword (Adamu 1999). Adamu highlights the constant tension African Muslim women experience as they are exposed simultaneously to more conservative forms of Islam and the hegemony of Western feminists both of which they resist to create their own autonomous conceptualization of development (Narayan 1997). Much like Chandra Mohanty's disruption of the construction of non-Western women as a passive monolithic group, my study analyzes the varied experiences of Muslim women as development actors to illustrate their use of economic agency to challenge intersecting social and political power structures (Mohanty 1988). Mainstreaming gender, as an analytical frame is essential because it interrogates privilege, illustrates how it is distributed among and between women and men and provides insights into partnerships that cab be forged across genders. The Muslim women's organizations that are the focus of this study are using their civil society organizations to represent the interests of women in development and public policy

The works of Amina Mama and Ayesha Imam provide insights into how African Muslim women conceptualize their multiple identities and negotiate between what can at times be viewed as competing sets of interests with material, social and political consequences (1996, 2003). It also provides a context to understand the relationships of identity, interests, and the formation of organizations to attain outlined goals. In addition to Islamic identities, socioeconomic status, lineage, level of Islamic and secular education, age and other factors also impact women's perspectives. Muslim women's CSOs illustrate a focus on different development issues and strategies utilized to address them. African Muslim women actively resist externally constructed definitions of Muslim women by their male counterparts and western approaches to development. (Oyewumi 1997& 2003, Ogundipe-Leslie 1994, Adamu 1999, Lemu 2007, Jamal 2007, Alidou 2005, Kabir 2011) Adamu uses the phrase "double edged sword" to highlight the constant tension African Muslim women experience as they

are exposed simultaneously to more conservative forms of Islam (that they often resist) and the hegemony of Western feminists (1999). While Muslim women are framing of gender equality and development on their own terms, they are also able to partner at times with international organizations and at times provide substantive feedback to government ministries. The ability to cultivate these connections is directly related to the social locations of women within the organizations. The political significance of Islam and experiences of Muslim populations are varied particularly with respect to national context. Therefore, I am arguing that through careful analysis of the structures of NGOs and CBOs in addition to their institutional relationships with each other and interactions with political institutions it is possible to map forms of gender privilege as it relates to identity categories. Additionally depending on their structures NGOs and CBOs are potentially equipped to represent multiple interests of women in ways that differ from female legislators and ministers because they function outside of the institutional constraints of the state and are active on the ground.

Muslim Women's CSOs As Designers Of Development

There are a myriad of perspectives of Muslim women on development, however I want to begin this section with two quotes that illustrate women's ability to interpret their own roles in Islam in ways that are consistent with not in conflict with their NGO and CBO activities.

Haj. AUY a member of the Muslim Sisters Organization, which plays an advisory role to FOMWAN, highlights the ability of Muslim women to define their own roles in development and their contributions to their family, community, and country:

In terms of there [allegedly] being a conflict between western education and being a Muslim woman…[it is possible] that you could be educated in the western sense but you could still uphold your values of being a traditional Hausa Fulani woman. Ah uh still be able to carry out those roles…So and I am allowed to engage in economic activities which do not compromise my position as a wife and mother and a Muslim woman. I provide job opportunities for over 100 people, which I feel I am contributing something to the economy of the country. To the people around me and also no matter how small it is, it is pushing the wheel of progress forward. (Interview with Adryan Wallace)

Haj. Hadiza the director of GHON echoes a similar sentiment about the synergy between Islam and education for women:

Women should be educated…Because from what I know of my religion Islam tells me, it doesn't deprive any woman from attaining education. (Interview with Adryan Wallace)

Both Haj. Auy and Haj. Hadiza demonstrate that women are resisting critiques from men in their communities that their work is in conflict with their Islamic identities and

resisting the approaches to development championed by western feminists, which often reinforce global economic hierarchies that use constructs of gender equality that use neoliberal assumptions. They see promoting women's empowerment and development as part of their identities and roles as Muslim women. Both women are very privileged however it is precisely their social location that allows them to engage in development work without being financially dependent on it (Wallace 2014). As I examine the activities of NGOs below the importance of mainstreaming the diverse interests of women is highlighted and these strategies.

Fomwan and Ghon- Kano, Nigeria

Since 2001 Kano state offered free maternal health services, but there was no existing policy plan or law to regulate the terms and delivery of services. FOMWAN drafted a material health bill, in collaboration with other CBOs and groups, to help ensure that obstacles impeding all women from having equal access to state maternal health services are remedied. FOMWAN has offices in thirty-four states and connections to over five hundred women's organizations both registered and unregistered groups. FOMWAN's direct efforts to maintain connections to CBO groups helped integrate concerns from grassroots women that are often excluded. These efforts are reflected in the ways the organizations facilitate collective exchanges. Given the organizational structure of FOMWAN, members of NGOs and CBOs are selected to represent the interests of their respective groups and in turn work together in committee, based on consensus (shurah), to devise the organizations larger platform. Even when services may be available, it is imperative that there are guidelines to ensure equal access and it is important that grassroots women are able to actively participate in this element (Wallace 2014). FOMWAN, through proposing the maternal health bill, created a space for women in NGOs and CBOs to devise legislation that mainstreamed elite and grassroots women's priorities through consensus to include issues related to transportation costs and other hidden fees, level of comfort communicating their needs to the staff, food security and other concerns. FOMWAN has also been able to collaborate with international organizations giving women from community based organizations (CBOs) access to stakeholders that the CBOs would not be able to acquire independently.

GHON, unlike FOMWAN, used another approach. GHON is a development organization, working to ensure that the health needs of grassroots women defined by local CBOs were addressed at the local level. Additionally, GHON equipped women in development CBOs with connections to the formal LGA political institutions capable of resolving issues they face related to accessing health care facilities. These local women's groups are now able to engage the relevant political institutions to address their concerns regarding the improvement of health factors and other areas, if they

choose to do so. In addition to areas such as health, GHON highlights the broader contributions women can make to society in the areas of development. Under Sharia, in this particular Islamic context, delineating between the public and the private is not pronounced; therefore, changes in any one sector have direct implications on the other. Sadia, an employee of GHON, states that historically women were "…considered to be more at home or their work must be involved [in] home and the family. They are not recognized in the educational, health and everything to do outside. But as time goes on our people were able to identify that women [have] roles to play even in the outside society" (Haj. Sadia, Interview by Adryan Wallace, Kano, Nigeria, November 11, 2011). Hausa women are successfully translating their needs associated with domestic activities into political claims particularly in the areas of health (Imam 1997).

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Ewid-Fomwag & Elder- Youth CBOs- Tamale, Ghana

EWID is a member of the Coalition of NGOs in Health, which attempts to develop a symbiotic relationship with the Ministries of Health in their respective districts. Haj. Hajara the executive director of EWID established the organization in 2004. EWID was created to ensure that Muslim women in northern Ghana were fully integrated into society particularly as it relates to protecting their rights, civic responsibilities and ability to advocate for development policies that are geared toward addressing gender inequalities in health, education and other sectors. Since 2004 EWID has conducted a myriad of activities however I will highlight two of their most recent programs. The first is increasing women's participation in decision making and the second, working with the network of NGOs in health to streamline activities, increase partnerships and decrease duplication of efforts. In 2008 they conducted a preliminary assessment of the knowledge that women in five local communities had about their roles in decision making at the community level. The following year they traveled to seven communities to conduct similar programs. Subsequently in 2010 they conducted a two-day workshop with twelve female aspirants for national assembly in eight electoral areas, Gindabour, Tuna, Sawla, Nakwabi/Blema, Kalba, Sangyeri, Kperibayiri and Jentilepe. The workshop focused on addressing concerns and challenges posed by the female candidates and strengthened their leadership qualities, assertiveness, public speaking skills, advocacy and lobbying skills. The elections in December resulted in the historic election of two women to national assembly in the Sawla and Nakwabi districts respectively. EWID continues to monitor the impact of their workshops in the local communities. They partnered with IBIS on this project.

In addition to her work with EWID Haj. Hajara Telly is also the president of the Tamale branch of FOMWAG. The impetus of FOMWAG began in Nigeria after FOMWAN was established. In Ghana, FOMWAG primarily focuses on workshops and programs for its members to raise awareness about issues that impact their lives and relevant legal and policy reforms. In January 2011 FOMWAG members attended the conference on marriage registration held in Tamale. The other into meeting was held in Accra, the south. There have been difficulties with compliance to marriage registration regulations and FOMWAG members were able to provide critical insights for their non-Muslim counterparts about how to improve the process and increase the number of Muslims that register their marriages. FOMWAG was also invited to attend the constitutional review conference and selected the four areas as a focus: National Development and Planning, Decentralization and Local Government, and Human Rights. In February of 2011 FOMWAG participated in the national anti-corruption action plan regional consultations. Haj. Telly going specifically in her capacity as president of the FOMWAG Tamale in order to raise the visibility of Muslim women and ensure that their interests are being included and mainstreamed the national agenda. There are approximately thirty members of FOMWAG in Tamale that are Hausa only a few of which are actually from the Hausa zongo. The organization does intend to more directly invite more women from the Hausa zongo to join.

The Zongo community of Hausa in Tamale is primarily a self contained unit. They do not receive direct support from NGOs or local state offices. Less than five women of the cooperatives in the zongo trade in any of the primary markets in Tamale. Instead women have set up mini stores and markets within the community. The primary economic activities of the women involve trading. They have established over thirty trading cooperative groups organized according to the products being sold. The majority of items include food stuffs and beads. The groups meet once a week to discuss any

obstacles and provide support to each other. In addition to trade there are small numbers of women that act as intermediaries between buyers and sellers of recycled gold. In addition to the trading groups there is also an elders group that meets once a week to discuss more macro level issues that are impacting the women and community. The head of the Elder CBO teaches Quranic classes for adult women because she views having a strong religious foundation as essential to anything else an individual produces. The ages of women in the cooperatives range from sixty to thirty, with the majority of women in their 40s and 50s.

In Tamale FOMWAG has members from different levels of society and everyone works together with the only stratification being the eboard ,which is comprised of individuals elected to leadership positions. There are approximately thirty Hausa women that are members of FOMWAG Tamale, with a total membership of over four hundred women. There are many Muslim women of different ethnic and linguistic backgrounds however the Hausa women specifically from the zongo writ large do not comprise a large percentage of the Hausa women that are members of FOMWAG. FOMWAG is in the process of reaching out to establish more formal linkages with the Hausa women in the zongo who appear to be more insular than their other Muslim counterparts in the North.

In addition to conducting programs centered upon increasing the number of women elected to public office, EWID also plans to have capacity building workshops for female politicians so they are able to make tangible impacts in terms of policy and physical infrastructure if elected to office. This approach stands in stark contrast to the Hausa women in Kano who were more circumspect about the role of women in politics and directly engaging them to push their own development agendas.

Sahiba- Dar Es Salaam, Tanzania

SAHIBA Sisters is an organization established as a trust in 1997 is "a development network whose mission is to enhance the leadership and organizational capacity of women and youths community actors, as individuals or in groups so as to facilitate their informed engagement in civil society." They are active in the following thirteen regions in Tanzania-Mwanza, Manyara, Morogoro, Dodoma, Iringa, Mbeya, Kilimanjaro, Dar es Salaam, Lindi Town, Tabora, Kigoma, Songea, Zanzibar (Unguja and Pemba). The organization is supported through voluneteer work and is an informal NGO with links to other smaller groups. In particular they focus on mainstreaming the perspectives of a diverse range of women into development processes because they are often left out of key discussions. Their key constituents include Muslim women, elderly women, young women, women lacking formal education or facing geographical barriers to political participation. Sahiba has chosen a holistic institutional approach by working at the

national, local and community levels. In particular efforts to increase the participation of young women is viewed as essential. Furthermore, Sahiba argues that "professional women's organizations" that "viewed poor women as objects needing salvation and not as subjects with agency" served to further marginalize rather than empower women. It is important to highlight that none of the organizations selected for this study are "professional women's organizations" because the leadership is not dependent on revenue from their development work for their own financial security (Wallace 2014). Sahiba also criticizes religious leaders for echoing the tactics of "professional women's organizations" when they advocate conservative interpretations of Islam casting women as submissive rather active agents of political change capable of advancing their own agenda. By operating as a trust Sahiba avoids the global governance of development donors and instead advance their self-defined conceptualization of development and associated programming with a social justice focus.

They function as an umbrella organization for NGOs and CBOs that are often unregistered including 200 members of women and men that want to contribute in their capacities as individual actors. A true grassroots effort was undertaken in establishing their network through attending local mosques, women's organization, meetings, etc. There are over 48 member organizations. As my work illustrates that in Muslim women's groups in West African use religious and cultural frames to promote gender equality and inclusive development Maoulidi echoes a similar sentiment for Muslim women in East Africa (Wallace 2014; Maoulidi 2002).

African Muslim Women's Development Appraoches –Lessons for The Brics-Regional and Sub-Regional Integration

There are several key features of the BRICS new efforts towards development aid specific to Africa as a region. The recent establishment of the BRICS 50 billion USD New Development Discuss the and which will serve as a "feasible and viable" means "for mobilizing resources for infrastructure and sustainable development projects in BRICS and other emerging economies and developing countries, to supplement the existing efforts of multilateral and regional financial institutions for global growth and development" (BRICS 2014:11) The Contingency Reserve Agreement (CRA) totaling 100 billion USD will address immediate or short-term liquidity problems which can enhance economic stability. Their key regional priorities include the development of physical and development infrastructure consistent with the "framework if the African Unions (AU) New Partnership for Africa's Development (NEPAD)" and the Regional Economic Communities, a BRICS-AU Commission-NEPAD Planning and Coordinating Agency (NPCA) as technical arm. Finally, the establishment of an African-BRICS transnational/ cross-border infrastructure development fund that assists with the implementation of

projects and conducts feasibility studies was recommended (Guimei 2014).

While these efforts are laudable there are three areas in which the BRICS approach to development reinscribes existing neoliberal paradigms. I argue below that these issues can be addressed by the BRICS development model learning from the successful strategies of local Muslim women's organizations in Nigeria, Ghana and Tanzania in designing their own development aims, mainstreaming diverse perspectives, and improving policy recommendations and evaluation.

First, they are attempting to increase their participation and influence in existing international and multinational development institutions while also attempting to develop their own development bank their loyalties are split (Esteves & Gama 2014). The result can culminate in the employment of similar goals, emphasis on growth and the current neoliberal models given that they attempting to advance their positions in those institutions. In other words rather than fundamentally changing the global economic systems they are advocating for equal participation. The Muslim women CSOs in this study take different approaches to addressing these challenges. All of the organizations have eliminated any exclusive dependence on external aid structures or financial revenues that afford them with the autonomy required to focus on the needs of marginalized and grassroots women. Sahiba Sisters is functionally a trust and therefore solely utilizes volunteer work for day-to-day operations. They prioritize their sets of interests rather than focusing on changing international development organizations. The fact that they are able to conduct development programs that are not exclusively dependent on external funding from the west groups select programming based on their own inclusive agenda. The programs do have an impact on development discourses because they represent a different type of engagement but their perspectives are not always mainstreamed.

The second limitation of the BRICS approach to development is that there is no institutional place for CSOs to help design development agendas, shape policy and engage in monitoring and evaluating the success of programs. This omission could provide a space for local Muslim women's organizations to fill this void. Each of the organizations mentioned has relationships with grassroots CBOS, including FOMWAN, FOMWAG, Sahiba Sisters and GHON. The first three are membership organizations while GHON serves to place CBOs in a position to provide direct feedback to the state and political institutions regarding the government's ability to successfully deliver goods and services. The CBOs that each of the larger NGOs works with vary in size and amounts of privilege. Some are registered with the state and some are not illustrating that women engaged in CBO work are often more economically vulnerable than their NGO counterparts (Wallace 2014). The direct connection to the grassroots could provide the BRICS with the ability to center women's voices in development, have CSOs shape policy frameworks and programs and provide accountability mechanisms which can identify bottle necks on the ground and spearhead their resolution. These are capacities that the BRICS are lacking.

Finally the lack of coordination of regional AU, sub-regional COMESA, SADC, ECOWAS, EAC are concerns that have been raised (Souza 2014). This challenge also speaks to a more fundamental problem of negotiating the competing interests of the members of BRICS in addition to the national development goals of other emerging markets that might seek funding from the new development bank. The institutional linkages of women's organizations both within and across national contexts strengthens that ability of African countries to look internally and share their development best practices through sub-regional entities and the African Union

state level-national-provincial/state-local, sub-regional (COMESA, ECOWAS, EAC). FOMWAN and FOMWAG have an institutional connection and Muslim women's organizations that are not treating development as a business would be able to collaborate because although their strategies may vary their goals are the same. They are also able to translate a myriad of women's interests into policy i.e. the maternal health bill and constitutional reform. I would recommend that the BRICS establish an advisory role for local Muslim women's CSOs that function similar to groups that were the focus of this study and task the CSOs with also streamlining development and economic policies of the sub-regional groups to create consistency with the BRICS-African Union through NEPAD initiative. The result would be transformative because the women's CSOs are active in multiple sectors including human rights, which gives them institutional experience working wit sub-regional and regional policy and legal instruments (see table 1 below which outlines the links between BRICS development goals and Muslim women's CSO development programs). These efforts can provide much needed synergy among these regional and sub-regional groups and the goals of the BRICS and replace the tendency to use neoliberal frames with cooperative ones.

Conclusion

Development agendas and programs often reflect the priorities of the state and political administration. During the last twenty years Muslim women in West Africa have become more involved in development (education, economic, health) work through the establishment of non- governmental (NGOs) and community based organizations (CBOs). There four specific best practices utilized by the women's groups in this study that could be adopted to generate a new approach to holistic development practices.

First, in addition to conducting programming women have also become involved in shaping the discourses around development and impacting decision frameworks used by the state to distribute the resources. Social categories such as the category woman are very diverse and often contentious. Therefore this work captured the dynamic relationships among Muslim women, which reflect the ways divergent interests of Muslim women are represented to the political system. Furthermore centering the experiences of African

Muslim women obviates tendencies to homogenize interpretations of women and politics in Islamic contexts, and instead illustrates the myriad of perspectives, which exist. Some scholars employ Islam as a variable to measure the constraining affects traditional cultural perspectives have on the political participation of women. By working at the intersections of politics, economics, identity, culture, religion, and gender the agency exhibited by these organizations can be illustrated.

Next, I selected CSOs that consist of non-governmental organizations and community based groups in an effort to underscore the efforts of each organization to mainstream and advocate the intersecting interests of women from the grassroots and women that are more affluent. By illustrating this range given their own social locations serves to create a definition of development that is inclusive by representing the breadth of perspectives and not treating women and their development needs as monolithic. Muslim women's organizations in this study have managed to work across socio-economic strata and social location largely because of their institutional structure and their commitment to an inclusive and holistic conceptualization of development. They have also been able to use religion and culture to create progressive development frames that emphasize gender equality.

Third, this ethnographic study revealed how varied perspectives within and across Muslim groups are translated into different strategies to mainstream gender equality into development and policy discussions. The ability of national umbrella Muslim women's groups like FOMWAN and FOMWAG to at their own discretion decide to collaborate with international organizations, demonstrate how to successfully navigate what could be perceived as divided loyalties between "western" and "local" definitions of development. Additionally, the strategies of these groups to maintain autonomy while asserting inclusive models of development could benefit the BRICS new development bank and avoid neoliberal economic models.

Finally, I argued that using the examples of these CSOs and making them a central part of the policy process, trade negotiations, and monitoring and evaluating processes the BRICS, AU, and sub-regional bodies and the national governments could exercise agency and employ a method of disruptive and changing development discourse. Local Muslim women's groups should be a formal advisory role to the BRICS development bank. It will ensure that the true designers of development are no longer marginalized and are instead progenitors of a new approach to inclusive sustainable development.

Table 1: Examples of Local Muslim Women's NGOs & CBOs Development Agendas & Programs in Kano, Nigeria, Tamale, Ghana, Dar es Salaam, Tanzania

Name	Country	Development Work	Institutional Affiliations
Federation of Muslim Women's Associations in Nigeria (FOMWAN)	Nigeria	Maternal health bill Polio vaccines Community health outcomes Monitoring elections Building schools Girls education	Trading CBOs Community CBOs
Grassroots Health Organization of Nigeria (GHON)	Nigeria	Increasing access to health care facilities Clean water & sanitation Women's Reproductive Health HIV/AIDS Trainings for women's trading cooperatives, business development, micro-credit	Trading CBOs TBA CBOs Community Development CBOs
Enterprising Women in Development (EWID)	Ghana	Civic rights trainings Elections Workshops with female aspirants for national assembly Health Women's and girls education Decision making role in community trainings for women	Coalition of NGOs in Health Community Based Groups
Federation of Muslim Women's Association in Ghana (FOMWAG)	Ghana	Human Rights in Islam Trainings Constitutional Review Conference National Marriage Registration	Umbrella network for Muslim women across ethnicities
Sahiba Sisters	Tanzania	Young Women's Internship program Leadership & Governance Reproductive & Health Rights & HIV/AIDS Women's Human Rights Adult Education Gender Based Violence Resource Mobilization & Wealth Creation	Over 48 registered and unregistered NGOs & CBOs

References

Adamu, Fatima. 1999. "A Double-Edged Sword: Challenging Women's Oppression Within Muslim Society in Northern Nigeria." *Gender and Development* 7(1): 56- 61.

Adedeji, Adebayo. 2004. "The ECE: Forging a Future for Africa", in *Unity and Diversity in Development Ideas: Perspectives from the UN Regional Commissions,* ed. By Yves Berhelot, 2330306. Bloomington: Indiana University Press.

Alidou, Ousennia D. 2005. *Engaging Modernity: Muslim Women and the Politics of Agency in Postcolonial Niger.* Madison, WI: University of Wisconsin Press.

Alvesson, Mats and Yvonne Due Billing. 2009. *Understanding Gender and Organizations*. London: SAGE.

Armijo, Leslie. 2007. "The BRICS Countries (Brazil, Russia, India and China) As an Analytical Category: Mirage or Insight", in *Asian Perspective* 31(4):7-42.

Callaway, Barbara J. 1987. *Muslim Hausa Women in Nigeria: Tradition and Change.* Syracuse, NY: Syracuse University Press.

Campbell, Marie L. and Kathy Teghtsoonian. 2010. "Aid Effectiveness and Women's Empowerment: Practices of Governance in the Funding of International Development." *Signs* 36(1): 177–202.

Cornwall, Andrea. 2003. "Whose Voices? Whose Choices? Reflections on Gender and Participatory Development", *in World Development* 31(8):1325-1342.

Cornwall, Andrea, Elizabeth Harrison, and Ann Whitehead. 2004. "Introduction: Repositioning Feminisms in Gender and Development." *IDS Bulletin* 35(4): 1–10.

Debusscher, Petra and Anna van der Vleuten. 2012. "Mainstreaming Gender in European Union Development Cooperation with Sub-Saharan Africa: Promising Numbers, Narrow Contents, Telling Silences." International Development Planning Review 34(3): 320–38.

Esteves, Paulo, Abdenur, Erthal and Gama, Carlos. 2014. "BRICS and global governance reform: a two-pronged approach in *Papers of the Fifth BRICS Academic Forum Partnership for Development Integration & Industrialization* 52-59.

Gammeltoft, Peter. 2008. "Emerging Multinationals: Outward FDI from the BRICS countries", *Paper Presented in the IV Globelics Conference at Mexico City, September 22-24 2008.*

Glosny, Michael. 2010. "China and the BRICs: A Real (but Limited) Partnership in a Unipolar World", in *Polity* 42:100-129.

Guimei, Yao. 2014. "BRICS economic and trade cooperation with Africa", in *Papers of the Fifth BRICS Academic Forum Partnership for Development Integration & Industrialization.* 82-87.

Hau, Matthias, Scott, James, and Hulme, David. 2012. "Beyond the BRICs: Alternative Strategies of Influence in the Global Politics of Development," in *European Journal of Development Research*24:187-204.

Imam, Ayesha. 1997. "The Dynamics of WINing." *In Feminist Genealogies, Colonial Legacies, Democratic Futures*, edited by M. Jacqui Alexander and Chandra Talpade Mohanty, 280-307. New York: Routledge.

Jamal, Amina. 2007. "Islam: Islam and Modernities-Overview." In *Encyclopedia of Women & Islamic Cultures, Volume: 5 Practices, Interpretations and Representations,* edited by Suad Joseph, 209–15. Boston: Brill.

Kabeer, Naila. 2005. "Gender equality and women's empowerment: a critical analysis of the third Millennium Development Goal"., in *Gender and Development 13(1):*13-24.

Kabir, Hajara. 2011. *Northern Women Development: A Focus on Women in Northern Nigeria, Vol.1.* Print Serve Limited.

Kimenyi, Mwangi & Lewis, Zeina. 2011. "Foresight Africa: The Continents' Greatest Challenges and Opportunities for 2011." In *Africa Growth Initiative,* Brookings Institute.

Kleinmon, Sherryl. 2007. *Feminist Fieldwork Analysis: Qualitative Research Methods.* Sage Publishers: London.

Kubik, Jan. 2009. "Ethnography of Politics: Foundations, Applications, Prospects." In *Political Ethnography: What Immersion Contributes to the Study of Politics,* edited by Edward Schatz, 25-52. Chicago: University of Chicago Press.

Lemu, Aisha. 1980. *A Degree Above Them: Observations on the Condition of the Northern Nigerian Muslim Woman*. Karachi, Pakistan: Islamic Education Trust

MacDonald, Martha. 1995. "Feminist Economics: From Theory to Research." Canadian *Journal of Economics* 28(1): [159-76].

Maoulidi, Salma. 2002. "The Prediciment of Muslim Women in Tanzania", in Gender, *ISIM Newsletter: 25.*

Mama, Amina. 1996. *Women's Studies and Studies of African Women During the 1990's.* Working Paper Series 5/96. Dakar: CODESRIA.

_______. 2001. "Challenging Subjects: Gender and Power in African Contexts"., *African Sociological Review.,* 5(2), 63-73. Pleanary Address Nordic African Institute Conference "Beyond Identity Rethinking Power in Africa", Upsala October 4-7, 2001.

Mikell, Gwendolyn. 1997. *African Feminism: The Politics of Survival in Sub-Saharan Africa.* Philadelphia: U of Pennsylvania P, 1997.

Mkandawire, Thandika. 2014. "The Spread of Economic Doctrines and Policymaking in Postcolonial Africa", in *African Studies Review,* 57(1): 171-198.

Moyo, Dambisa. 2009. *Dead Aid: Why Aid is not Working and How There is a Better Way for Africa*. Farrar, Straus and Giroux: New York.

Narayan, Uma. 1997. *Dislocating Cultures: Identities, Traditions, and Third World Feminism.* New York: Routledge.

Nager, Richa and Susan Geiger. 2007. "Reflexivity and Positionality in Feminist Fieldwork Revisited. In eds. Adam Ticklell, Eric Sheppard, Jamie Peck and Trevor Barnes, *Politics and Practice in Economic Geography.* London: Sage, 267-278.

Nikkhah, Hedayat, Ma'rof Redzuan, and Asnarulkhadi Abu-Samah. 2012. "Development of 'Power within' among the Women: A Road to Empowerment." *Asian Social Science* 8(1): 39-46.

Oyewumi, Oeronke. 1998. "De-confounding Gender: Feminist Theorizing and Western Culture, a Comment on Hawkesworth's 'Confounding Gender.'" *Signs* 23(4): 1049-62.

Pittin, Renée. 1991. "Women, Work and Ideology in Nigeria." *Review of African Political Economy* 19(52): 38-52.

Rathgeber, Eva M. 1990. "WID, WAD, GAD: Trends in Research and Practice." *The Journal of Developing Areas* 24(4): 489-502.

Ruwanpura, Kanchana N. 2007. "Awareness and Action: The Ethno-gender Dynamics of Sri Lankan NGOs." *Gender, Place & Culture: A Journal of Feminist Geography* 14(3): 317-33.

Schoeman, Maxi. 2011. "Of BRICS and Mortar: The Growing Relations between Africa and the Global South", in *the International Spectator: Italian Journal of International Affairs* 46(1) 33-51.

Sharma, Ruchir. 2012. "Broken BRICs", in *Foreign Affairs* November/December Comment 2012.

Souza, Andre. 2014. "Brazil's development cooperation in Africa: a new model?", in *Papers of the Fifth BRICS Academic Forum Partnership for Development Integration & Industrialization.*
96-107.

Tripp, Ali. 2012. "Donor Assistance and Political Reform in Tanzania", in *UNU World Institute for Development Economics Research 37*:1-26.

Wallace, Adryan. 2014. "Agency Through Development: Hausa Women's NGOs & CBOs in Kano Nigeria", *in Special Issue on Gender and Economics in Muslim Communities, in the Journal of Feminist Economics*-Forthcoming.

___________. 2014. " *in the Black Women in Politics: Identity, Power and Justice in the New Millennium, in the National Political Science Review 16:*67-80.

La contribution des jeunes à l'alternance politique au Sénégal : Le rôle de Bul faale et de Y'en a marre

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Résumé

Ce document est une contribution à l'étude du rôle des jeunes dans les processus de démocratisation en Afrique. Plus spécifiquement, il se borne à analyser l'influence de Bul Faale et de Y'en a marre dans les deux alternances politiques survenues au Sénégal en 2000 et 2012. Ces deux mouvements, issus du hip-hop, ont été au premier plan dans les mobilisations qui ont permis ces changements de majorité au pouvoir. Cela contraste avec la situation de marginalisation politique et économique dans laquelle se trouvent les jeunes.
***Mots-clés:** Sénégal, jeunes, alternance politique, Bul faale, Y'en a marre*

Abstract

This paper is a contribution to the research on the role of youth in the democratization process in Africa. More precisely, its analysis is confined to the influence of Bul Faale and Y'en a marre in political changes that occurred in Senegal, both in 2000 and in 2012. Always originating from hip-hop, these two movements have been at the forefront of mobilizations that sparked changes in the ruling majority. Interestingly, this contrasts with the situation of political and economic marginalization the youth continues to struggle with.
***Keywords:** Senegal, Youth, Political Change, Bul faale, Y'en a marre*

Introduction

Le Sénégal est l'un des pays africains les plus étudiés. Beaucoup de choses ont été dites sur sa stabilité et sa démocratie, soit pour les mettre en évidence, soit pour montrer les limites. En termes de réussites, l'on évoque souvent le fait que le Sénégal n'ait jamais connu de conflit majeur, de coup d'État, de situation d'État en faillite (Stepan, 2012), de clivages sociopolitiques d'ordre religieux (O'Brien, 1992). À cela s'ajoute le fait qu'il soit pionnier en matière de libéralisation politique en Afrique (Coulon, 1992). La jeunesse sénégalaise, à la différence de la majorité des jeunes africains témoins et victimes de

l'expérience des dictatures ou des conflits (Mbembe, 1985), a donc pu évoluer dans un contexte sociopolitique plus favorable. Du point de vue de cet héritage de stabilité et d'ouverture politique, son rôle devient dès lors un sujet d'étude pertinent, d'autant plus que contrairement à ce que l'on pourrait penser, la jeunesse sénégalaise souffre de marginalisation, aussi bien sur le plan économique qu'en matière de représentation politique. D'ailleurs, une documentation importante a tenté de traduire cet état de fait. C'est le cas de la littérature sur les mouvements « élèves et estudiantins » (Bathily, 1992 ; Bianchini, 2002 ; Dimé 2014b ; Zeilig, 2004), sur la jeunesse urbaine et ses difficultés (Diouf, 1992 ; 2002 ; Gérard, 1993 ; Bouchard, 2007 ; Dimé, 2007), ou encore sur les générations contestataires imprégnées de hip-hop (Abrahams, 2013 ; Awenengo Dalberto, 2011 ; Thiat, Cissokho, 2012 ; Dimé, 2014a ; Gueye, 2013 ; Haeringer, 2012 ; Havard, 2001 ; 2013 ; Moulard, 2014 ; Ngom, 2012 ; 2013 ; Savané, Sarr, 2012). Le sujet traité de manière assez récurrente dans ces études demeure la jeunesse de la grande métropole dakaroise, appréhendée principalement à travers ses élans de survie et de contestation de l'ordre sociopolitique.

Dans ce document, nous étudions la contribution des jeunes au processus de démocratisation politique au Sénégal. L'angle d'approche privilégié s'insère dans la perspective d'analyse d'un sujet majeur, à savoir le rôle politique d'une jeunesse majoritaire sur le continent ainsi que l'influence qu'elle exerce sur les dirigeants. Le Sénégal compte 12 873 601 habitants, dont 52,7 % âgés de moins de 20 ans (ANSD, 2014, p. 18), et 30 % situés entre 20 et 39 ans (Awenengo Dalberto, 2011, p. 38) ; ce qui cause, comme ailleurs sur le continent, d'énormes pressions et de défis en matière d'emploi, d'éducation et de formation. De prime abord, il convient de préciser que la jeunesse, faite de « réalités sociales et sous-générationnelles variées » (Awenengo Dalberto, 2011), est impossible à saisir de manière univoque (Mbembe, 1985, p. 6). Compte tenu de ces réserves, l'analyse, au lieu d'aborder la jeunesse sénégalaise dans toute sa complexité et son étendue, tente d'en cerner quelques traits saillants à partir de deux mouvements : *Bul faale* et *Y'en a marre.* L'hypothèse de base de notre réflexion repose sur l'idée selon laquelle ce sont les jeunes engagés dans ces mouvements, qui ont été aux avant-postes des événements qui auraient fait et défait le Président Abdoulaye Wade. Arrivé au pouvoir en 2000 grâce à la vague du *Sopi* (changement en wolof) poussée par les jeunes de la génération *Bul faale* (ne t'en fais pas), Abdoulaye Wade a fait face, en 2012, à une forte tendance pour le changement remorquée par le mouvement *Y'en a marre* au cœur de l'imposant élan populaire ayant permis sa défaite électorale et l'élection de Macky Sall. De ce constat, il en ressort un engagement décisif des jeunes dans les deux alternances politiques réalisées jusqu'ici au Sénégal. Dans l'un et l'autre cas, les jeunes se sont projetés au premier plan, en mobilisant des discours percutants ainsi qu'un répertoire d'actions créatives et audacieuses.

Étudier l'issue de l'engagement politique des jeunes et la manière dont celui-ci s'est décliné présente plusieurs intérêts. Les changements de majorité au pouvoir auquel ils ont contribué sont d'une grande portée, quand on sait combien le « contrat social

sénégalais » (O'Brien, 1992) et les réseaux confrériques pèsent sur l'organisation sociale et l'État postcolonial. D'ailleurs, pendant 40 ans, ce système a permis à Léopold Sédar Senghor (1960-1980) et à son successeur Abdou Diouf (1981-2000)[1] de préserver le pouvoir. L'étude du rôle des jeunes et de leurs actions dans la vie démocratique sénégalaise s'avère aussi intéressante, du fait notamment de la dimension historique de leurs apports. La place de celle-ci dans l'analyse a un fondement relativement simple : un État démocratique sans histoire serait un État sans avenir (Rigaudière, 2006, p. 11). Les jeunes, à travers Bul faale et Y'en a marre, se trouvent au carrefour de la démocratie sénégalaise et de son histoire.

Ces mouvements sont issus d'un domaine d'engagement prisé par les jeunes, à savoir le rap. Celui-ci a permis à une jeunesse en difficulté et tenue à l'écart des débats et des instances de décision économique et politique, de s'exprimer et de s'imposer dans l'espace sociopolitique. Apparu dans les années 1990, *Bul faale* est un mouvement socioculturel qui rejette le fatalisme, une des caractéristiques de l'imaginaire sénégalais, et milite pour l'émancipation, le changement et la rupture par rapport au système de valeurs héritées de l'ancienne génération jugée responsable de la crise (Havard, 2001). Les mêmes tenants ont présidé à la naissance, en 2011, de *Y'en a marre*, qui s'est également appuyé sur la musique rap, érigé en levier de critique sociale et d'actions pour le changement. L'opérationnalisation de telles dynamiques se frotte, inévitablement, à certaines normes traditionnelles sénégalaises comme le *sutura* (discrétion), le *sag* (honneur), le *maslaa* (conciliation). Or, celles-ci vouent un respect fondamental aux plus âgés. Abdoulaye Wade, opposant historique porté à la tête de l'État sénégalais en 2000 à l'âge de 74 ans, a été combattu avec virulence entre 2011 et 2012 par les jeunes de *Y'en a marre*, alors qu'il avait plus de 85 ans. Une autre caractéristique commune aux deux mouvements serait en lien avec le fait que leur engagement ait pris pied dans un contexte particulier, où les préoccupations exprimées dans les revendications sont partagées par une large frange de la population. Cela a sans doute contribué à leur essor. Celui dont bénéficie *Y'en a marre* semble être beaucoup plus fulgurant. En tout cas, aucun mouvement de jeunes sénégalais n'a jamais réussi à gagner autant de popularité et à faire l'objet de curiosité et de débats aussi importants (Dimé, 2014 ; Havard, 2013 ; Gueye, 2013 ; Moulard, 2014 ; Savané, Sarr, 2012 ; Awenengo Dalberto, 2011 ; 2012 ; Thiat, Cissokho 2011 ; Haeringer, 2012).

Dans un premier temps, nous mettons en exergue certaines tendances lourdes qui caractérisent la jeunesse sénégalaise, cela pour en savoir davantage sur les différentes catégories de jeunes, leurs rapports à l'État, aux partis et à la politique. Dans le sillage de cette analyse, l'on verra le rôle de la génération *Bul faale* dans l'avènement de la première alternance politique au Sénégal en 2000. Dans un second temps, il est question des écarts de gouvernance du régime de Wade, lesquels écarts ont favorisé l'émergence de plusieurs mouvements d'opposition dont *Y'en a marre*. Enfin, nous verrons que le

1 *Abdou Diouf a été Premier ministre du Sénégal pendant presque onze ans (26 février 1970 – 31 décembre 1980).*

désarroi des jeunes, au lieu d'être un élément démobilisateur, a plutôt servi de leitmotiv au mouvement qui a largement contribué à la défaite électorale de Wade en 2012.

Considérations générales sur la jeunesse sénégalaise

Pour une meilleure compréhension, quelques considérations générales sur la jeunesse sénégalaise s'imposent. En effet, elles servent à retracer le profil de cette jeunesse à travers une typologie voire une classification, laquelle permet de mieux saisir le rôle prégnant de *Bul faale* dans l'alternance politique de 2000.

La jeunesse sénégalaise : Typologies et tendances dominantes

Plusieurs catégories se dégagent de la jeunesse sénégalaise. La catégorisation classique repose sur la distinction entre jeunesse scolarisée et jeunesse non scolarisée. La jeunesse scolarisée regroupe les élèves et les étudiants ainsi que les jeunes qui travaillent ou chôment à l'issue de leurs études ; tandis que la jeunesse non scolarisée englobe les jeunes qui n'ont pas fréquenté l'école. On peut aussi faire une autre catégorisation des jeunes, selon qu'ils se trouvent dans les zones rurales ou dans les villes. La jeunesse urbaine est largement scolarisée et politisée (Gérard, 1993, p. 108). La plupart des jeunes ruraux, eux, vivent temporairement dans les villes, exercent dans le secteur informel à Dakar et habitent principalement dans ses banlieues et quartiers populaires.

Étant donné les difficultés économiques et la mobilité des jeunes, les frontières entre jeunesse urbaine et jeunesse rurale, jeunesse scolarisée et jeunesse non scolarisée deviennent à la fois mouvantes et floues. Même l'informel qui emploie 4,1 % des jeunes âgés de 15 à 24 ans et 31 % de jeunes situés dans la tranche d'âge 25-35 ans (ANSD, 2013, p. 29), est loin d'être un paramètre de démarcation pertinent. Outre les personnes en provenance des villages et n'ayant aucun niveau d'étude (27,7 %), ce secteur engage en effet un large éventail de Sénégalais scolarisés. Certains ont arrêté leurs études au primaire (28,2 %), d'autres au niveau du secondaire (18 %), d'autres encore ont fait des études supérieures (4,5 %) (ANSD, 2013, p. 21). De même, on y trouve une forte proportion d'urbains dont 19 % de Dakarois et 48,2 % d'entrepreneurs issus des autres villes du Sénégal (ANSD, 2013, p. 22). Notons que des jeunes, qu'ils soient scolarisés ou non, se trouvent également dans les villes dans des métiers divers : mécanique, transport, construction, menuiserie, réparation, restauration, etc. Dans le même temps, d'autres s'adonnent à des activités parallèles, dont la « délinquance de subsistance » (Mbembe, 1985).

De 1960 à la fin des années 1990, c'est la jeunesse scolarisée (élèves et étudiants) qui a été au premier plan dans les luttes syndicales et événements majeurs ayant jalonné l'histoire politique du Sénégal (Bathily, 1992 ; Dimé, 2014b ; Gérard, 1993 ; Zeilig, 2004). Cependant, cette force de mobilisation ne s'est pas traduite en position de pouvoir au sein des partis politiques2. Or, il y a un besoin criant de renouvellement générationnel dans la direction de ces organisations, surtout dans un pays qui abrite l'une des classes politiques les plus vieilles du continent (Diouf, 2012), et où on constate une conscience démocratique assez développée chez les jeunes, scolarisés ou non (Sy, 2011, p. 62-63). Comparativement aux profils des jeunes de l'indépendance marqués par les réalités coloniales, la jeunesse sénégalaise des années 1990-2000 qui englobe ceux des mouvements dont il est ici question, semble être moins imprégnée d'idéologies et plus proche de la société. Cette dernière posture mise en exergue par Mamadou Diouf (1992) a été perceptible à travers l'implication des jeunes dans les associations sportives, culturelles et religieuses ; la contestation des pouvoirs publics et l'érection des quartiers comme lieu d'autonomisation et de sociabilité[3]. En matière de contestation, l'on perçoit que les jeunes ne se distinguent en rien des Occidentaux du même âge qui n'hésitent pas à se mobiliser « pour des enjeux qui leur tiennent à cœur » (Quéniart, Jacques, 2008). Cependant, à la différence de ces derniers peu attirés par le processus électoral (Benett, 1997 ; Galland, Roudet, 2001), la jeunesse sénégalaise semble porter, à certains moments, une attention particulière aux élections présidentielles.

Le rôle décisif de la jeunesse dans l'alternance de 2000

Sous Abdou Diouf (1981-2000), le Sénégal a connu le multipartisme intégral consacré par une prolifération de partis politiques, de nombreux syndicats ainsi qu'une pléthore de mouvements associatifs. Le pays devait également composer avec une crise multiforme4. D'ailleurs, c'est dans ce contexte précaire que surgit le phénomène Bul faale (qui signifie ne t'en fais pas en wolof), en tant que mode d'expression et de revendication chez les jeunes. Il est issu du mouvement rap[5] des années 1990[6], avant d'être popularisé à la fois par Positive Black Saoul (PBS), le premier groupe de rap sénégalais – à travers sa cassette de 1994 qui porte le même nom –, et par des figures emblématiques du hip-hop (Dedier Awadi, Doug E.Tee, Bibson, Xuman, etc.) et de la lutte à l'instar de Mohamed Ndao Tyson. Le mouvement Bul faale est avant tout un mode de pensée et d'action célébrant la liberté et l'esprit d'entreprise dans une perspective d'affirmation de soi et de réussite individuelle (Havard, 2001), mais aussi un appel au changement, donc un symbole de la contestation de l'État et des traditions politico-religieuses (Assogba, 2007). L'angle d'approche demeure éminemment politique, puisqu'il s'agit d'aller à l'assaut du régime socialiste au pouvoir depuis l'indépendance du Sénégal, par des critiques stigmatisant l'inefficacité et la mauvaise gouvernance.

Aux yeux de cette jeunesse durement touchée par le spectre du chômage et de la précarité, ce qui importe c'est le changement de régime. Abdou Diouf, candidat du Parti socialiste (PS) à l'élection présidentielle 2000, l'avait bien saisi et avait fait du changement

2 Même si les partis ont souvent des cellules de jeunes.

3 Le mouvement Set-Setal (propre et rendre propre), par exemple.

4 Troubles scolaires, violences urbaines, pauvreté galopante, crise des lieux traditionnels de socialisation (famille, école, université) ; autant de phénomènes entraînés ou aggravés par les programmes d'ajustement structurel des années 1980 et la dévaluation du Franc CFA (1994).

5 Animé par plusieurs groupes, tels que Daara J, Positive Black Saoul, Bibson ak Xuman, Rapadio, Xalima.

6 Le rap gagne très vite en popularité grâce à l'émergence de radios privées comme Sud FM (1994) et Walf FM (1997).

son thème de campagne, à travers des slogans comme « Ensemble, changeons le Sénégal », « Le siècle change, signé Abdou Diouf », etc. Or, les jeunes avaient bien compris que le changement n'était pas son atout, d'où les corrections apportées aux affiches : sur « Ensemble, changeons le Sénégal », il est réécrit « l'alternance ou la mort » ; « Le siècle change, signé Abdou Diouf » devient « Le siècle change, sans Abdou Diouf ». Le choix du changement comme thème de campagne a été perçu comme une usurpation, notamment par les jeunes pour qui Abdoulaye Wade, le leader du Parti démocratique sénégalais (PDS), incarne le véritable changement (le « Pape du changement »).

En campagne électorale, celui-ci avait l'habitude de demander aux jeunes : « Que ceux qui n'ont pas de travail lèvent la main ». Servie avec un succès retentissant à chaque occasion, cette phrase était une forme de diatribe (contre le candidat sortant), accompagnée de promesses sur l'emploi, la justice sociale et la lutte contre la corruption, lesquelles promesses nourrirent l'espoir de lendemains meilleurs chez les jeunes. Cela arrivait à point nommé, puisque dans le répertoire d'action de Bul faale figurait, outre les contestations, l'engagement citoyen ainsi que le vote comme prise de parole politique. La force de l'engagement des jeunes pour le compte du Sopi, « signe de ralliement de tous les mécontents » (Coulon, 1992, p. 4), a été de créé un climat de fin de partie pour le régime socialiste alors « à bout de souffle » (Dahou, Foucher, 2004). En ce qui concerne l'expression citoyenne, on peut noter le fait que des rappeurs et des étudiants aient sillonné Dakar et le reste du pays en caravane pour pousser le monde rural à rallier le Sopi et pour encourager la participation électorale des jeunes : inscription, votes, surveillance et vigilance le jour du scrutin. Au sujet du vote, l'enjeu s'avérait hautement important, d'autant plus que la majorité électorale est passée de 21 à 18 ans[7], un changement obtenu en 1993 grâce au combat mené par l'opposition dirigée par Abdoulaye Wade. Ainsi, beaucoup de jeunes ont pu s'inscrire sur les listes électorales en 2000 : sur les 2 618 176 électeurs, 1 127 100 avaient entre 18 et 35 ans, soit 43 % des inscrits (Zeilig, 2004).

Déjà affaibli par la perte de son électorat traditionnel et le départ de certains leaders populaires du Parti socialiste[8], Abdou Diouf finit par perdre les élections au deuxième tour, le 19 mars 2000, au profit d'Abdoulaye Wade (58,5 % des voix) alors âgé de 74 ans. En joignant l'acte de vote à un certain nombre de postures comme la contestation de l'ordre sociopolitique, l'appel à la rupture, l'effort de sensibilisation et de veille pour un scrutin transparent, les jeunes deviennent ainsi les principaux artisans de la première alternance survenue au Sénégal. Ils ont donc voté pour Wade ou appelé à voter pour lui, non pas pour la personnalité du candidat ou pour son programme, mais pour en finir avec le parti socialiste au pouvoir depuis 40 ans.

Ce qui semble paradoxale, c'est la réélection d'Abdoulaye Wade en 2007, malgré une situation économique difficile. Toutefois, il n'a jamais été prouvé que les rappeurs et les

7 À la suite d'une modification du code électoral intervenue le 7 février 1992. République du Sénégal, Code électoral, Loi n° 92-16 du 16 février 1992.

8 Dont Moustapha Niasse et Djibo Leity Kâ.

vedettes du hip-hop aient quelque chose à voir avec sa victoire. Tel que rapporté par le documentaire African Underground : Democracy in Dakar (2007), certains d'entre eux ont même vainement utilisé la musique pour empêcher sa réélection[9]. D'autres, sous l'influence de l'argent offert par le régime, ont pu voter pour Wade, contribuant ainsi à sa reconduction dès le premier tour avec 55,9 % des voix. Deux ans après, soit le 22 mars 2009, il perd les élections législatives à Dakar et dans la plupart des grandes villes du pays. Cette fois-ci, cela ne fait aucun doute, les jeunes ne se sont pas mobilisés à ses côtés (Awenengo Dalberto, 2011), certains lui ont même opposé des réactions hostiles durant la campagne électorale[10].

L'apparition de *Y'en a marre* dans un contexte d'indignation

En 2000, après 40 ans de régime socialiste, Abdoulaye Wade est élu président de la République du Sénégal pour un mandat de sept ans, c'était le premier changement de majorité dans ce pays. Mais il n'a pas su répondre aux attentes de la population, surtout des jeunes qui ont été au cœur de sa campagne électorale et largement contribué à sa victoire. Au contraire, sa présidence a favorisé un climat d'indignation et l'émergence de plusieurs mouvements parmi lesquels se trouve *Y'en a marre*.

Un contexte d'indignation généralisée

En 2000, Abdoulaye Wade fraîchement arrivé au pouvoir se trouvait face à de fortes attentes de la société sénégalaise. Quelques années après, les conditions économiques ne se sont pas améliorées. Dans le même temps, les acquis démocratiques semblaient être foulés aux pieds. Ce constat a longuement été mis en exergue par des observateurs de la vie politique sénégalaise. Certains d'entre eux se sont attelés à alerter l'opinion publique sur des faits spécifiques comme la violence[11] (Havard, 2004 ; Coulibaly, 2011), les scandales politico-financiers (Diop, 2007 ; Coulibaly, 2009 ; Gaye, 2010 ; Kitane, 2010), ou encore la remise en question d'un grand nombre de traditions soigneusement entretenus au Sénégal, comme la laïcité et le respect des autorités religieuses (Kane, 2001 ; Stepan, 2012). C'est à croire que l'État sénégalais a été « poussé dans l'abîme des mœurs » (Gellar, 2005) ; d'où sa présentation comme une « République abîmée » (Coulibaly, 2011) dont il fallait rétablir l'honneur, à commencer par la lutte contre la « crise des valeurs et des institutions » (Mendy, 2012).

Concrètement, la révolte s'est déclinée dans des formes inédites : immolations par le feu, contestations de rue dans les petites villes du pays, manifestations contre les violences

9 African Underground : Democracy in Dakar, documentaire produit par Nomadic Wax, réalisé par Ben Herson et Magee McIlvaine.

10 Ports de brassards rouges en signe de mécontentement, brûlages de pneus, huées, jets de pierres, etc.

11 Censure, dérives policières, arrestations arbitraires, intimidations anonymes et menaces de morts, agressions physiques contre des acteurs politiques et des journalistes, etc.

politiques, marche de journalistes contre l'impunité et les agressions, révoltes de jeunes « marchands ambulants », marches et protestations d'imams contre la vie chère et les coupures d'électricité, *Barca wala Barsàq* (Barcelone ou la mort), organisation des assises nationales. Le mécontentement pouvait se lire, par ailleurs, à travers l'apparition de multiples organisations civiques et politiques aux titres pour le moins évocateurs, comme *Dafa doy* (ça suffit), *Luy jot jotna* (il est temps), *Taxaw temm* (debout de manière décidée), *Y'en a marre*, autant d'intitulés qui traduisent le rejet dans lequel se trouvait le pouvoir en place. À commencer par *dafa doy,* l'expression est souvent utilisée quand on est excédé par le comportement ou le discours d'un individu, à qui on intime l'ordre d'arrêter. C'est dire à quel point la société en avait marre du « système Wade » et de ses dérives ; d'où l'alerte à l'opinion publique nationale sur la nécessité de s'en départir, en restant debout de manière déterminée (*Taxaw temm*) pendant qu'il était encore temps (*Luy jot jotna*). De ce point de vue, Y'*en a marre* n'a pas été le premier à appeler les Sénégalais à se séparer d'Abdoulaye Wade, puisque chacune de ces organisations, en s'insurgeant contre le régime politique, prétendait représenter *askan wi* (le peuple) et en être son *kàddu* (porte-voix).

Entre 2000 et début 2012, il y a donc eu un divorce entre le régime d'Abdoulaye Wade et une bonne partie de la population sénégalaise. L'opposition la plus radicale provenait des jeunes, la catégorie sociale la plus touchée par le chômage et la précarité. Entre 2001 et 2005, la part d'inactivité chez les jeunes passe de 32 % à 35 % (Perspectives économiques, 2012). En 2008, le taux de chômage global était estimé à 48 %, dont 60 % de jeunes âgés de moins de 35 ans (YEN-IYF, 2009). Les multiples projets mis en œuvre pour résorber le chômage et le sous-emploi des jeunes[12] ont été sans succès face aux 100 000 nouveaux diplômés qui arrivent chaque année dans le marché de l'emploi (YEP, 2010, p. 11). Pour les chômeurs, d'autres voies comme le secteur informel, l'émigration clandestine désespérément tournée vers Barca wala Barsàq (Barcelone ou la mort), la lutte, la musique et la danse, s'imposent. Ces différents champs de prédilection peuvent être considérés comme autant de modes de survie et de résistance face aux difficultés en matière d'emploi, de formation, etc. Ce qui est intéressant à relever, ce sont les capacités protestataires des jeunes qui, au lieu d'être écrasées sous le poids des problèmes quotidiens, se renforcent, notamment dans la grande banlieue de Dakar (Havard, 2001)13 d'où est issu le mouvement Y'en a marre.

L'émergence du mouvement Y'en a marre

Le mouvement *Y'en a marre* est formé entre le 15 et le 16 janvier 2011 aux parcelles

12 *Agence d'exécution des travaux d'intérêt public (AGETIP), Fonds national de promotion de la jeunesse (FNPJ), Plan d'action national pour l'emploi des jeunes (PANEJ), Office pour l'emploi des jeunes de la banlieue (OFEJBAN), Retour vers l'agriculture (REVA), Agence nationale pour l'emploi des jeunes (ANEJ), Haut Conseil de l'emploi et de la formation.*

13 *Fort taux d'analphabétisme, inflation, manque d'eau, dégradation des infrastructures routières, pauvreté, sous-emploi, chômage, inégalités, insécurité, inondation, insalubrité, délestages, etc.*

assainies (Unité 160), un quartier de la banlieue de Dakar par cinq jeunes : Fadel Barro, Cheikh Omar Cyril Touré plus connu sous le nom de Thiat (le dernier de la famille), Mbessane Seck alias Kilifeu (le sage), Simon et Alioune Sané. La plupart d'entre eux sont des rappeurs. Thiat et Kilifeu font partie du groupe de rap *Keur Gui* (la maison), tandis que Fadel Barro (coordonnateur du mouvement) et Alioune Sané sont journalistes. Ils seront rejoints par Malal Talla (surnommé Fou malade) du groupe *Bat'haillon Blin-D* et d'autres rappeurs. Les fondateurs du mouvement ont tous fait des études, certains ayant même été à l'Université Cheikh Anta Diop de Dakar. Grâce à cette convergence de profils de rappeurs et de journalistes, spécialistes du jugement critique sur l'actualité, *Y'en a marre* bénéficie d'une grande maîtrise de la rhétorique, du témoignage et de la mobilisation, combinant à la fois l'imagination artistique, l'esprit critique et l'art de communiquer dans les médias et les réseaux sociaux. Un tel leadership explique sans doute l'habileté avec laquelle il a déployé et coordonné ses ressources et ses actions, avec des routines organisationnelles dont *Bul faale* était dépourvu, mais encore moins rodées comparativement aux formations politiques et aux syndicats qui ont une expérience reconnue dans ce domaine.

À l'origine, le mouvement est une histoire de copains (savané, Sarr, 2012) qui, au cours d'une discussion sur les difficultés de la société sénégalaise, décident de rompre avec le fatalisme et l'inaction. Selon Fadel Barro, son coordonnateur et journaliste à *La Gazette* :

« À l'époque, la vie au Sénégal était rythmée par des coupures intempestives d'électricité, des scandales financiers à coups de milliards, une injustice sociale extraordinaire, l'arrogance du régime de Abdoulaye Wade dont le système et ses hommes affichaient une indifférence face aux souffrances de la population. À l'époque, on s'était senti abandonné en tant que citoyens sénégalais. Abandonnés par les élites politiques, syndicales, maraboutiques… Il n'y avait quasiment personne pour se faire l'écho sonore de nos frustrations et de nos préoccupations. Autour de ces réflexions et discussions, on a décidé une nuit de mettre sur pied un mouvement qui s'appelle 'Y' en a marre' »[14].

La création de *Y'en a marre* n'était pas sans lien avec l'actualité internationale de l'époque, puisqu'elle est intervenue deux jours après la fuite du Président Zine El-Abidine Ben Ali en Arabie Saoudite (14 janvier 2011), dans le sillage de la révolution tunisienne. Ses membres fondateurs ont sans doute été influencés par ce qui se passait en Tunisie et en Égypte. Le type de contestation mené par *Y'en a marre* contribue sans doute au renouvellement des modes d'action collective, rendu favorable par la spécificité de l'espace urbain qui, à la différence du milieu rural, constitue un véritable théâtre d'expression de l'imagination créative des jeunes (Gawa, 2014). Au début du mois de mars 2011, le mouvement a commencé à faire circuler la pétition ci-dessous intitulée « Les mille plainte contre le gouvernement du Sénégal », et qui a reçu des centaines de milliers de signatures.

14 *Voir, Fadel Barro, dans un entretien avec le journal burkinabé, Lefaso.net, 6 juillet 2012. Consulté sur Internet (http://www.lefaso.net/spip.php?article48994) le 12 janvier 2015.*

Questionnaire devant être rempli par toute personne souhaitant s'engager dans le mouvement Y' en a marre

Prénom/Nom…………………………………
Adresse………………………………………
Activité………………………………………

Y' EN A MARRE
OBJET : Plainte contre le gouvernement du Sénégal

Je suis citoyen, je perds des journées de travail, je dors dans le noir à cause des délestages
Pourtant, je paie ma facture
Je suis malade, je n'ai pas accès aux soins élémentaires
Pourtant, c'est mon droit
Je suis père de famille, mon salaire ne couvre plus les besoins élémentaires de mon foyer
Je suis mère de famille, mon panier est dégarni
Pourtant, on m'a fait rêver 2000
Je suis élève, ma scolarité est compromise
J'ai mon bac, je ne suis pas orienté, je suis étudiant, je n'ai pas de bourse
Je suis enseignant, je peine à percevoir mon maigre salaire
Je me demande où sont passés les 40 % du budget de l'éducation nationale ?
Je suis paysan, j'ai cru à la GOANA et au REVA
Pourtant, je n'ai plus de semences, je ne vends plus ma récolte et on me doit 22 milliards
Ils m'ont promu une maison à Jaxaay, et pour ça, ils ont reporté les élections en 2007
Et jusqu'à présent, ma famille vit l'enfer des inondations
Je suis marchand ambulant, je suis traqué de partout
Pourtant, je veux juste un espace où gagner ma vie.

Depuis plus d'une décennie, le gouvernement de mon pays se montre incapable de satisfaire mes besoins vitaux. Subjugué qu'il est par la demande sociale, je dis Y'EN A MARRE ! Et je compte, par cette présente, faire valoir mes droits en exigeant que la justice me soit rendue. Je porte plainte pour flétrir le train de vie dispendieux du Gouvernement du Sénégal. Pour dénoncer l'hypocrisie et la cupidité de ces autorités qui ont trompé le peuple, conquis le pouvoir pour en faire un instrument de propagande personnelle.

Je porte plainte pour dire halte à la corruption, à la démagogie, à la supercherie politique et pour revendiquer le droit à une existence juste plus décente et plus humaine.

Signature

Le mouvement *Y'en a marre* s'est illustré dans la contestation, sûrement en raison de sa capacité à exprimer explicitement les difficultés que vit la majorité des Sénégalais. Pour ces derniers, cela voulait dire aussi que quelque chose avait changé : ne plus continuer à endurer les épreuves et à réprimer la colère, seulement parce que l'harmonie et la paix sociale sont à préserver. Cela est particulièrement mis en évidence, nous semble-t-il, par le Collectif des Imams et résidents de Guédiawaye et de la banlieue, apparu en 2008, dans le quartier dont il porte le nom. D'habitude, dans des situations de crise, les Imams se positionnent en régulateurs par des appels au calme, en accord avec l'interprétation de la religion qu'ils représentent (l'islam) et qui incite plus souvent à accepter bien des choses, même les plus insupportables, au nom de Dieu. Or, face à la vie chère et aux coupures d'électricité récurrentes, les Imams ont été les premiers à dire non dans la rue et à mettre en garde le régime, avec leur banderole phare : « *Góor gui*[15] faut pas déconner, sinon on va déconner ». Le paradoxe à souligner réside dans le calme de la vie politique sénégalaise pendant presque dix ans, malgré les difficultés économiques persistantes. C'est seulement en juin 2011 que le calme sera rompu par le projet de modification constitutionnelle proposant d'élire conjointement le président de la République et son vice-président avec 25 % des suffrages exprimés.

De la crise préélectorale à l'alternance de 2012 : le rôle de *Y'en a marre*

Les élections présidentielles ont souvent été des périodes de tensions. Celle de 2012 a été marquée par la crise préélectorale liée au projet de modification constitutionnelle, puis à la candidature du Président Abdoulaye Wade. Dans l'un et l'autre cas, tout comme dans le processus électoral, *Y'en a marre* a joué un rôle déterminant.

L'opposition de Y'en a marre au « ticket présidentiel »

Beaucoup de Sénégalais voyaient dans le projet de réforme de 2011 appelé aussi « ticket présidentiel » une confirmation de l'intention longtemps prêtée à Abdoulaye Wade de hisser son fils, Karim Wade, au sommet du pouvoir de l'État. Des voix s'élèvent de partout pour dénoncer une tentative de « succession monarchique ». Le 23 juin, jour où le projet devait être soumis à l'Assemblée nationale, des jeunes de *Y'en a marre* ont décidé de se retrouver dans la rue pour manifester leur opposition. D'autres forces issues de mouvements citoyens, des syndicats, des partis politiques d'opposition, etc., sont venues s'y greffer. Sur les pancartes dressées ici et là à la Place Soweto (devant l'Assemblée nationale), on pouvait lire : « Touche pas à ma Constitution », « Halte à la monarchisation de l'État », « Démocratie en danger », « Wade dégage ». L'ampleur de la mobilisation des jeunes a été sans précédent.

En effet, jamais on n'avait vu s'exprimer autant de détermination chez les jeunes (Gueye, 2013, p. 28), qui ont « déserté les amphithéâtres, boycottés le rituel des trois normaux,

15 Ou le vieux, surnom donné à Abdoulaye Wade.

ignoré les chemins qui mènent au stade et aux arènes de lutte pour s'approprier une passion qui frise l'irrationnel le mot d'ordre 'Touche pas à ma Constitution' » (Sy, 2012, p. 25). Comme pour dire que dorénavant, « quand on refuse on dit non » (Kourouma, 2004), avec un « non » catégorique. Le mouvement *Y'en a marre* a joué un rôle de premier plan dans cette dynamique de refus, qui se réalise dans un contexte international où les mouvements d'indignation ont fait de l'occupation de la rue et des lieux symboliques une pratique courante. Dans le contexte sénégalais, ce mode d'action semblait plus efficace, eu égard aux habitudes du régime de Wade. À un moment donné, celui-ci estimait qu'il n'avait plus d'opposant significatif, tellement ses projets et ses initiatives aboutissaient sans encombre. En tout cas, « l'opposition républicaine » privilégiée par les formations politiques a été sans succès face aux nombreuses modifications constitutionnelles[16].

Jusqu'à la veille de l'exposition du projet de loi sur le « ticket présidentiel » à l'Assemblée nationale sénégalaise le 23 juin 2011, les leaders de la société civile et de l'opposition politique, fidèles à leur ligne de conduite, en étaient encore au stade des analyses et des discours. Il aura donc fallu l'impatience et l'engagement physique des jeunes de *Y'en a marre* pour précipiter la descente dans la rue. Sans avoir la prétention de refaire l'histoire, on peut supposer que sans la pression de la rue, le projet aurait abouti et qu'on aurait, peut-être, jamais vu apparaître le mouvement du 23 juin ou M23 (regroupant *Y'en a marre*, les partis politiques d'opposition et des organisations de la société civile). Si ces deux dernières composantes ainsi que d'autres jeunes n'étaient pas intervenus, *Y'en a marre* n'aurait sans doute pas la réputation qu'il a eue. Le succès des manifestations du 23 juin a certainement donné au mouvement la force et la confiance qui lui ont permis de se mobiliser par la suite contre la candidature de Wade.

L'opposition à la candidature d'Abdoulaye Wade

Une des forces de *Y'en a marre* réside dans sa capacité à trouver les formules et les mots qui traduisent justement les problèmes auxquels les Sénégalais doivent faire face. L'usage du français et du wolof dans le rap, le principal vecteur de sensibilisation, permet aux jeunes, qu'ils soient chômeurs, ouvriers, mécaniciens, marchands ambulants, élèves, étudiants, entre autres, de saisir le contenu des messages. Un autre facteur de cohérence réside dans l'action :

> « *Traduire les paroles en actes à travers la création d'un mouvement permet d'arrondir les angles, d'évacuer les clivages liés aux goûts et aux couleurs pour ne plus laisser que le message. Toutes les tranches d'âge peuvent se retrouver si le discours est cohérent, si le discours est le discours du peuple* » *(Thiat, Cissokho, 2011).*

16 *Rétablissement du Sénat et du Conseil économique et social en 2007, retour du septennat en 2008, création du poste de vice-président en 2009, etc.*

Le mouvement *Y'en a marre* se situe même au-delà du récit, du témoignage et du cadre strictement politique, étant entendu qu'il appelle à la réforme des méthodes et comportements *via* le concept de Nouveau type de Sénégalais (NTS). Dans cette perspective, chaque citoyen est invité à incarner le NTS, en étant actif, respectueux des règles, des lois et de la chose publique, artisan de son propre destin de manière légale et contributeur responsable à un Sénégal meilleurs.

Ce que le mouvement semble réussir le mieux, c'est surtout l'érection du discours en mots d'ordre. En effet, l'engagement à travers le rap permet de voir que les textes peuvent être puissants pour impulser des réactions vives, comme la mobilisation contre la décision du président de briguer un troisième mandat en 2012. Dans cette perspective, la dissidence la plus radicale a été menée par *Y'en a marre*, à travers son single « Faux ! Pas forcé ! » :

« Abdoulaye, il faut pas forcer
Au nom du ciel ! Faut pas forcer !
Abdoulaye, en homme d'honneur !
Au nom du ciel ! Faut pas forcer !
Si de longues oreilles permettaient de mieux entendre
l'âne ne se ferait jamais battre
Ce que tu as détruit ici le singe ne l'a fait dans la forêt,
avoue que t'en peux plus
Abdoulaye ! Notre destin n'est pas entre tes mains, t'es
rien
On s'en fout de toi et des tiens
Abdoulaye ! Faut pas forcer !
Jongler avec la charte de notre patrie mère
Nous ne te laisserons pas faire Nous avons affaire à un
vieux menteur, tes erreurs, nous te les ferons avaler… »
(Y'en a marre Production ; Simon, Xuman, Kilifeu,
Faux ! Pas Forcé).

Au-delà de la détermination, la forme et le contenu de cet extrait semblent introduire une rupture. L'on sait que cela ne fait pas partie de la société sénégalaise gérontocratique, où l'aînesse représente une institution qui incarne l'autorité conférée par l'avantage lié à l'âge (Meillassoux 1994, p. 52), de manquer de respect aux adultes ; c'est une des composantes du « rituel de respect et de tolérance » dont parle Stepan (2012, p. 379). Le discours d'affront de *Y'en a marre* contre la candidature de Wade qu'il considère comme un faux pas qu'il ne faut pas forcer s'éloigne de l'esprit du nouveau type de Sénégalais respectueux des lois et des règles que le mouvement encourage. De plus, cela va à l'encontre du contrat générationnel tacite précédemment évoqué, d'autant plus qu'Abdoulaye, âgé de plus de 85 ans, semblait représenter une autorité double, en rapport avec les valeurs traditionnelles et son statut de président de la République. Après

la validation de la candidature de ce dernier par le Conseil constitutionnel en janvier 2012, *Y'en a marre* change d'objectif de lutte, et s'engage pour la défaite électorale du candidat sortant.

Le rap au secours du processus électoral

Dans son versant critique, tout comme dans le registre d'opérationnalisation des discours en plan d'action politique, le rap, tel qu'il est pratiqué par les jeunes, se distingue du *mbalax*, le genre musical le plus populaire au Sénégal. Celui-ci comprend des chansons d'amour, de sensibilisation, de louanges visant à s'attirer les faveurs de personnalités, mais aussi de paroles engagées. Mais la critique demeure ici assez marginale et ne hausse nullement le ton, comme cela se passe du côté des rappeurs de *Y'en a marre* dont l'approche rejoint le *zouglou* ivoirien, notamment sur le terrain du rejet des politiques et de leurs pratiques[17]. En revanche, le rap exprimé par cette catégorie de jeunes s'éloigne d'un type de musique très populaire, à savoir le *coupé décalé*. Celui-ci met sur piédestal le port vestimentaire et la possession matérielle (Gawa, 2014), une tendance d'apparence et une extravagance esthétique sublimées chez les jeunes ivoiriens dans un contexte de crise économique. Difficile à suivre pour la majorité d'entre eux, elle a pour conséquence de favoriser le recours à un ensemble de stratagèmes, ce qui vaut de penser que la fin justifie les moyens.

Les rappeurs de *Y'en a marre* s'inscrivent dans une perspective différente, dans la mesure où ils cherchent à impulser des changements politiques importants, et même fondamentaux en lien avec le NTS. Par conséquent, aucune autorité, aucun lieu de socialisation ne semblent épargné par la contestation, mais le mouvement s'insurge particulièrement contre l'instrumentalisation des électeurs et le *ndigël* (consigne de vote) que certains marabouts avaient l'habitude de donner à leurs disciples (citoyens). Dans son engagement contre l'utilisation des électeurs, le mouvement a fait preuve d'une publicité médiatique retentissante, avec des titres comme *Daas fanaanal* (se prémunir) et *Doggali* (achever un agonisant). Lancée à la fin du mois de mars 2011, l'opération *Daas fanaanal* ou « ma carte mon arme » mettait en exergue le sens et la portée de la carte d'électeur. À l'aide de « visites de proximité » (rencontres, porte-à-porte) et de « concerts pédagogiques », le mouvement a invité les Sénégalais, les jeunes en particulier, à sortir de l'indifférence et à faire usage de manière consciente de l'arme dont ils disposent, c'est-à-dire le vote. Ainsi, pendant que certains partis politiques parcouraient le pays en caravane de campagnes électorales, des *Y'en a marristes* sillonnaient également le « Sénégal profond » à la rencontre des jeunes, pour les pousser à s'inscrire, à aller voter et à faire triompher la « souveraineté populaire ». Ainsi, des milliers de Sénégalais ont pu s'inscrire sur les listes électorales (Gueye, 2013). Au premier tour du scrutin présidentiel du 26 février 2012, Abdoulaye Wade, candidat sortant, a obtenu 34,81 % des voix, suivi de Macky Sall (26,58 %).

17 *Enrichissements illicites, gaspillages, clientélisme, etc.*

L'entre-deux tours de l'élection présidentielle 2012 a été marqué par la chanson *Doggali* (achever un agonisant, un animal la plupart du temps), un programme de sensibilisation sur la nécessité de finir le travail commencé au premier tour : « Le plan doggali est une continuité, une suite logique dans notre lutte. On a dit aux jeunes allez-vous inscrire sur les listes électorales. Ensuite, on leur a dit, allez récupérer vos cartes. Les cartes ont servi dans un premier temps, mais dans l'arène si tu combats un adversaire et qu'il est presque à terre ; il faut l'achever »[18]. Concrètement, cela consistait à convaincre les citoyens à ne pas céder leurs cartes d'électeurs, avec un répertoire assez large de slogans : *jaay sa carte* = *jaay sa ngor* (vendre sa carte = vendre sa dignité), « ma carte ne se vend pas parce qu'elle est ma voix », « ma voix n'est pas à vendre », « non à l'achat de conscience », « il faut rester fiers et dignes ». L'entreprise a été payante, puisque le taux de participation a augmenté, passé de 51,58 % au premier tour à 55 % au second tour, à l'issue duquel Macky Sall[19], remporte l'élection avec 65,80 % des voix contre 34,20 % pour Abdoulaye Wade.

Y'en a marre s'est présenté comme un mouvement pacifique. De ce fait, il se démarque des organisations « élèves et étudiantes » dont le mode d'expression privilégié est la violence (Gérard, 1993). Pourtant, les titres de chanson comme *Daas fanaanal* et *Doggali* laissent transparaître une certaine violence. Pour vulgariser la nécessité de se départir du régime d'Abdoulaye Wade de manière sûre, le mouvement n'a donc pas hésité à s'appuyer sur ce qu'elle prétend rejeter – une violence certes verbale, mais qui tranche à la fois avec le pacifisme revendiqué et le contrat générationnel évoqué précédemment.

Par rapport aux autorités religieuses, la posture de défiance de *Y'en a marre* se manifeste à travers le rejet du *ndigël* politique. Le Nouveau type de sénégalais visé par le mouvement suppose une transformation des relations entre le marabout et ses *taalibe* ou disciples. Il faut préciser toutefois que le *ndigël* avait déjà commencé à s'effilocher. Pour rappel, en 2000, les consignes de vote données par certains marabouts (Cheikh Modou Kara Mbacké et Serigne Mansour Sy de la confrérie tidjane) n'avaient pas été respectées. Cette ligne de fracture que l'on considère comme le début du « désengagement de la population par rapport au *ndigël* » (Diop et al., 2000) semble se confirmer. En 2012, aucune des grandes familles religieuses (mouride et tidjane) n'ayant fait valoir de consignes de vote. Les deux qui se sont essayés, Cheikh ndigël Fall[20] et Cheikh Béthio Thioune, leader des thiantacounes – un groupe affilié à la confrérie mouride – pour le compte du candidat sortant ont été ignorés. Globalement, l'on constate que les disciples, bien qu'ils tiennent les marabouts en haute estime, notamment dans des domaines autre que politiques, préfèrent tourner le dos aux consignes au profit de l'affirmation citoyenne.

Dans le mode d'engagement des jeunes, il serait également intéressant de considérer la contribution de l'humour et des réseaux sociaux. En contexte de campagnes électorales, l'humour peut passer par les retouches apportées aux affiches des candidats aux élections,

18 *Thiat, lors d'une conférence de presse au quartier général de Y'en a marre, le 1er mars 2012.*

19 *Il a été soutenu par les douze candidats malheureux, l'équipe dirigeante des Assises nationales et par le célèbre chanteur Youssou Ndour.*

20 *Petit-fils de Cheikh Ibrahima Fall, serviteur d'Ahmadou Bamba Mbacké, fondateur du mouridisme.*

et vise la démystification de ces derniers et la transformation des symboles de l'autorité. À cela s'ajoute une forte tendance à se réapproprier les gaffes et les dérives des détenteurs du pouvoir pour se moquer d'eux d'un humour que l'on peut qualifier de « citoyen ». Les rappeurs, mais aussi une grande partie de la jeunesse sénégalaise, demeurent parties prenantes de ces courants de dérision. Mais de tels ne sont pas spécifiques au Sénégal, puisqu'on les retrouve dans d'autres pays africains. Dans « Jeu de mots, jeu de vilains : Lexique de la dérision politique au Togo », Comi Toulabor (1981) montre comment la dérision politique a été mise à profit à l'époque de Gnassingbé Eyadema, notamment par les Evé, l'ethnie majoritaire, qui en avait fait un instrument de contestation sociale pour amortir le discours du régime devenu dominant et écrasant. La dérision est diffuse dans l'espace social, mais son développement se fait dans les grandes villes et chez les jeunes, ce qui montre encore l'expression créative qui se réalise en milieu urbain.

À la suite de « Monsieur 15 % », Karim Wade, alors ministre de la Coopération internationale, des Transports aériens, des Infrastructures et de l'Énergie, portera ironiquement le surnom de « ministre du ciel et de la terre ». De même, les jeunes faisaient référence aux « 3T » pour parler de son père qui s'était illustré à la télévision et dans les voyages (*tukki* en wolof), notamment à Touba[21]. Le 14 juillet 2011, lors d'une rencontre tenue à l'Hôtel des Almadies en présence d'élus de son parti, le PDS, le Président Abdoulaye Wade a voulu mettre fin aux supputations au sujet de sa promesse de ne pas briguer un troisième mandat, en concluant par « *ma waxone, waxeet* » (je l'avais dit, je me dédis)[22]. L'expression sera la formule la plus célèbre dans les six mois qui ont précédé le scrutin présidentiel de 2012. Pour désigner le Président, l'on utilisait également « Wade, *wax waxeet* » (Wade, celui qui dit et se dédit) ou WWW, un clin d'œil fait à la fois aux « 3T » mentionnés précédemment et à Internet. D'ailleurs, l'Internet et les technologies de l'information ont également été au cœur de l'action de *Y'en a marre*. Concrètement, cela s'est traduit par l'échange de SMS, combinés à une forte présence sur Internet. La page Facebook du mouvement a été un imposant portail d'informations pour les jeunes et la diaspora.

Conclusion

Comme nous venons de le voir, *Bul faale* et *Y'en a marre* sont des mouvements de jeunes qui se sont posés avant tout comme catalyseurs de frustration. Si leurs actions trouvent un écho assez favorable, c'est parce qu'elles sont réalisées dans une période bien particulière d'inefficacité de l'action publique et de révolution médiatique sur fond de crise de représentativité politique et religieuse. Dans ce contexte, les mouvements de jeunes, plus à même de prendre en compte les revendications des populations, gagnent en crédibilité. L'évolution sociopolitique du Sénégal révèle le rôle prépondérant des jeunes. Beaucoup d'entre eux, en difficulté sous Abdou Diouf, ont œuvré pour son départ du

21 Ville de la confrérie mouride située à 150 km de Dakar.

22 Abdoulaye Wade, dans son discours à l'Hôtel des Almadies, Dakar, 14 juillet 2011.

pouvoir, en contribuant à l'élection d'Abdoulaye Wade. Témoins des promesses de celui-ci, les jeunes ont grandi sous sa présidence sans retrouver de perspectives meilleures ; d'où la naissance de *Y'en a marre*, qui a largement contribué à l'accession de Macky Sall au pouvoir. Autant en 2000 qu'en 2012, si l'écart de voix aux deuxièmes tours des élections présidentielles était assez important au point de ne laisser aucun choix aux candidats sortants, qui reconnaissent leurs défaites avant même l'annonce des résultats officiels, c'est, en grande partie, grâce à la mobilisation des jeunes, suivis par d'autres segments de la société (partis politiques d'opposition, syndicats, intellectuels, mouvements citoyens). Peut-être, en agissant ainsi ont-ils sauvé le Sénégal d'une crise postélectorale, un phénomène récurrent en Afrique. Le mouvement *Y'en a marre* réussira-il à garder le même entrain que celui qui l'avait porté entre 2011 et 2012 ? A-t-il épuisé le répertoire de ses modes d'action ? Ce qu'est sûr, c'est qu'il a réussi, du moins jusqu'ici, à se préserver de transactions douteuses avec le régime qui pourraient remettre en cause sa crédibilité[23]. C'est ce qui lui permet de demeurer dans son rôle de lanceur d'alerte. D'ailleurs, si l'on en croit le groupe de rap *Keur Gui*, membre fondateur de *Y'en a marre*, la situation du Sénégal demeure inchangée, et même s'aggrave, deux ans après l'accession de Macky Sall au pouvoir. C'est ce qui transparaît dans son clip *Diogoufi* (rien n'a changé) de l'album *Encyclopédie*, sorti en 2014 :

« Mêmes chats yi, mêmes chiens yi
(les mêmes chats, les mêmes chiens)
Mêmes va yi, mêmes vient yi
(les mêmes va-et-vient)
Les mêmes cas, les mêmes faits
Même cinéma, même schéma
Mêmes promesses électorales, même bradage du littoral
Reew mi K.O-total
(le pays est dans le chaos total)
Ñiaari at ñiep doyal
(deux ans et tout le monde en a marre)…
À quand le sérieux ? ». (Keur Gui, Diogoufi, album *Encyclopédie*)

Outre la critique sociale et les actions qu'il exerce au Sénégal, le mouvement *Y'en a marre* loue l'efficacité de sa démarche et pense que la lutte devrait s'étendre à d'autres pays africains. Une forme transnationalisation de la lutte citoyenne, qui a inspiré les jeunes du *Balai citoyen* au Burkina Faso et du mouvement *Filimbi* en République démocratique du Congo, et dont les dynamiques seraient intéressantes à étudier.

23 Rétributions financières, intégration dans le gouvernement ou dans l'administration, etc.

Bibliographie

Abrahams N., 2013, « Euroscapes in Senegal Seen through the Lense of the Hip Hop Movement », *L'espace politique*, 19 (1), http://espacepolitique.revues.org/2584 (accès le 10/05/ 2015).

Agence nationale de la Statistique du Sénégal, 2013, *Enquête nationale sur le secteur informel au Sénégal (ENSIS 2011), Rapport final*, Dakar, novembre.

ANSD (Agence nationale de la statistique et de la démographie), 2014, *Recensement général de la Population, de l'Habitat, de l'Agriculture et de l'Élevage (RGPHAE) 2013, Rapport provisoire*, Dakar, mars.

Assogba Y., 2007, « Exclusion et pratiques d'insertion des jeunes urbains en Afrique subsaharienne », in Y. Assogba (dir), *Regard sur… La jeunesse en Afrique subsaharienne*, Laval, Les Presses de l'Université Laval, p. 49-63.

Awenengo Dalberto, Séverine, 2011, « Sénégal : les nouvelles formes de mobilisation de la jeunesse », *Les carnets du CAP*, 15, p. 37-65.

Awenengo Dalberto, S., 2012, « De la rue aux urnes: la longue marche de l'alternance au Sénégal », http://www;sciencespo.fr/ceri/sites/sciencepo.fr.ceri/files/art_svd.pdf (accès le 15/02/2015).

Bathily A., 1992, *Mai 68 à Dakar ou la révolte universitaire et la démocratie*, Paris, Chaka.

Benett S., 1997, « Why Young Americans Hate Politics and what We Should Do about it », *Political Science and Politics*, 30 (1), p. 47-53.

Bianchini P., 2002, « Le mouvement étudiant sénégalais. Un essai d'interprétation », in M.-C. Diop (dir.), *La société sénégalaise entre le local et le global*, Paris, Karthala, p. 359-395.

Bouchard H., 2007, « Les jeunes commerçantes de Dakar : continuité ou changement? », in Y. Assogba (dir.), *Regard sur… La jeunesse en Afrique subsaharienne*, Laval, Les Presses de l'Université Laval, p. 105-122.

Coulibaly A. L., 2003, *Wade, un opposant au pouvoir. L'alternance piégée ?*, Dakar, éditions Sentinelles.

Coulibaly A. L., 2009, *Contes et mécomptes de l'ANOCI*, Paris, L'Harmattan.

Coulibaly A. L., 2011, *La République abimée*, Dakar, Éditions Sentinelles.

Coulon C., 1992, « La démocratie sénégalaise : bilan d'une expérience », *Politique africaine*, 45, p. 3-8.

Dahou T., Foucher V., 2004, « Introduction au dossier : Sénégal 2000-2004, l'alternance et ses contradictions », *Politique africaine*, 96, p. 5-21.

Dimé M. N., 2007, « Galérer, bricoler, contester et rêver : figures de la précarité juvénile à Dakar », in Y. Assogba (dir.), *Regard sur… La jeunesse en Afrique subsaharienne*, Laval, Les Presses de l'Université Laval, p. 123-143.

Dimé M., 2014a, « De *bul faale* à *Y'en a marre.* Continuités et dissonances dans les dynamiques de contestation sociopolitique et d'affirmation citoyenne chez les jeunes au Sénégal », *Child and Youth Studies Program : International Conference on Youth, Social Networks and Social Movements in Africa, Tunis*, 4-5 août.

Dimé M., 2014b, « Entre syndicalisme alimentaire et stratégie protestataire. Abdoulaye Wade et les étudiants : du héros adulé au patriarche déchu », *Mouvements étudiants en Afrique francophone. Des indépendances à nos jours*, Pré-actes du Colloque international, Université Paris 1, Paris, http://chs.univparis1.fr/MEAF.pdf (accès le 10/03/2015).

Diop M.-C., Diouf M., Diaw A., 2000, « Le baobab a été déraciné. L'alternance au Sénégal », *Politique africaine*, 78, p. 157-179.

Diouf M., Diop M.-C., 1990, *Le Sénégal sous Abdou Diouf*, Paris, Karthala.

Diouf M., 1992, « Fresques murales et écriture de l'histoire. Le Set/Setal à Dakar », *Politique africaine*, 46, p. 41-54.

Diouf M., 2012, « Sénégal : cinq leçons pour une crise », *Courrier international*, 7 février.

DPS (Direction de la prévision et de la statistique), 2004, *L'emploi, le chômage et les conditions d'activité dans l'agglomération de Dakar*, Dakar, Ministère de l'Économie et des Finances, http://www.ansd.sn/ressources/ rapports/Enquete 123_Phase1.pdf (accès le 12/12/2014).

Galland O., Roudet B., 2001, *Les valeurs des jeunes : tendances en France depuis 20 ans*, Paris, L'Harmattan.

Gawa F., 2014, « Le coupé décalé en Côte d'Ivoire : Sens et enjeux d'un succès musical », *Revue africaine de sociologie*, 18 (1), p. 112-126.

Gaye M., 2010, *Le Sénégal sous Abdoulaye Wade : banqueroute, corruption et liberticide*, Paris, L'Harmattan.

Gellar S., 2005, *Democracy in Senegal. Tocquevillian Analytics in Africa*, New York, Palgrave Macmillan.

Gérard J., 1993, « Élection présidentielle du Sénégal (février 1993) : "Sopi" pour la jeunesse urbaine », *Politique africaine*, 50, p. 108-115.

Gueye M., 2013, « Urban Guerrilla Poetry : The Movement Y'en a marre and the Socio-Political Influences of Hip Hop in Senegal », *The Journal of Pan African Studies*, 6 (3), p. 22-42.

Haeringer N., 2012, « *Y'en a marre*, une lente sédimentation des frustrations. Entretien avec Fadel Barro », *Mouvements,* 69, p. 151-158.

Havard J.-F., 2001, « Ethos "bul faale" et nouvelle figure de la réussite au Sénégal », *Politique africaine*, 82, p. 63-77.

Havard J.-F., 2004, « De la victoire du "sopi" à la tentative du "nopi"? "Gouvernement de l'alternance" et liberté d'expression des médias au Sénégal », *Politique africaine*, 96, p. 22-38.

Havard, J.-F., 2013, « Senghor ? Y'en a marre ! L'héritage senghorien au prisme des réécritures générationnelles de la nation sénégalaise », *Vingtième Siècle. Revue d'histoire*, 118, p. 75-86.

Kane O., 2001, « La République couchée », *Wal Fadjri*, Dakar, 8 mai.

Kitane A. K., 2010, *Le Sénégal sous Wade : cahiers d'une démocratie sans démocrates*, Paris, L'Harmattan.

Kourouma A., 2004, *Quand on refuse on dit non*, Paris, Seuil.

Mbembe A., 1985, *Les jeunes et l'ordre politique en Afrique noire*, Paris, L'Harmattan.

Meillassoux C., 1994, « La conquête de l'aînesse », in C. Attias-Donfut, L. Rosenmayr (dir.), *Vieillir en Afrique*, Paris, Puf.

Mendy T., 2012, *Crise des valeurs et des institutions sous Wade. Aux origines de l'incompétence politique*, Paris, L'Harmattan.

Moulard S., 2014, « Le regard entre deux rives. La migration et l'exil dans le discours des rappeurs sénégalais », *Cahiers d'études africaines*, 213-214, p. 415-449.

Ngom F., 2012, « Popular Culture in Senegal : Blending the Secular and the Religious », in F. Toyin, T. Fleming (dir.), *Music, Performance, and African Identities*, New York, Routledge, p. 97-124.

Niang A., 2013, « Le mouvement hip-hop au Sénégal. Des marges à une légitimité sociale montante », in M.-C. Diop (dir.), *Le Sénégal sous Abdoulaye Wade. Le Sopi à l'épreuve du pouvoir*, Paris, Karthala, p. 569-590.

O'Brien D. C., 1992, « Le contrat social sénégalais à l'épreuve », *Politique africaine*, 45, p. 9-20.

O'Brien D. C., Diop M.-C., Diouf M., 2002, *La construction de l'État au Sénégal*, Paris, Karthala.

Quéniart A., Jacques J., 2008, « Trajectoires pratiques et sens de l'engagement chez des jeunes impliqués dans diverses formes de participation sociale et politique », *Politique et Sociétés*, 27 (3), p. 211-242.

Rigaudière A., 2006, *Introduction historique à l'étude du droit et des institutions*, Paris, Economica.

Savané V., Sarr B. M., 2012, *Y'en a marre. Radioscopie d'une jeunesse insurgée au Sénégal*, Paris, L'Harmattan.

Stepan A., 2012, « Ritual of Respect. Sufis and Secularists in Senegal in Comparative Perspective », *Comparative Politics*, 44 (4), p. 379-401.

Sy A. M., 2011, *Le mal de jeunesse*, Dakar, Presses universitaires de Dakar.

Sy A. A., 2012, *Le 23 juin au Sénégal (ou la souveraineté reconquise)*, Paris, L'Harmattan.

Thiat, Cissokho S., 2011, « Y'en a marre, rap et contestation au Sénégal », *Multitudes*, 46, p. 26-34.

Toulabor C., 1981, « Jeu de mots, jeu de vilains : Lexique de la dérision politique au Togo », *Politique africaine*, 3, p. 55-71.

YEN-IYF (Youth Employment Network-International Youth Foundation), 2009, *Private Sector Demand of Youth Labour in Ghana and Senegal*, http://www.iyfnet.org/sites/default/files/psi_study.pdf (accès le 14/10/2014).

YEP (Youth Empowerment Program), 2010, *Evaluating Report Senegal*, http://www.iyfnet.org/sites/default/files/YEP_EvalReport_Senegal.pdf (accès le 18/10/2014).

Zeilig L., 2004, « En quête de changement politique : la mobilisation étudiante au Sénégal, 2000-2004 », *Politique africaine*, 96, p. 39-58.

Health Inequality in South Africa: A Systematic Review

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Abstract

This study presents a review of key empirical studies on health inequalities in South Africa with the aim of contributing to a comparative examination of social inequalities in health across different countries in Europe and other parts of the World. Studies reviewed were identified through a computerised search of key words such as inequalities, health, health inequalities, race, health in South Africa, health systems, socio-economic determinants of health and livelihoods in South Africa. Studies were included if the primary objective was to explore health inequality as a variable in child/adult mortality.
Keywords: *Health inequality, race, child mortality, socio-economic conditions, South Africa*

Résumé

Cette étude présente une revue des études empiriques clés sur les inégalités de santé en Afrique du Sud dans le but de contribuer à un examen comparatif des inégalités sociales de santé dans les différents pays d'Europe et d'autres parties du monde . Études examinées ont été identifiées par une recherche informatisée de mots clés tels que les inégalités , la santé, les inégalités en matière de santé , de la race , de la santé en Afrique du Sud , les systèmes de santé , les déterminants socio- économiques de la santé et les moyens de subsistance en Afrique du Sud . Des études ont été incluses si l'objectif principal était d'explorer les inégalités de santé comme une variable dans la mortalité des enfants / adultes
Mots-clés: *inégalités de santé , la race , la mortalité infantile , les conditions socio- économiques, l'Afrique du Sud*

Introduction

Research has shown that the health of the general population of a nation depends in part on access to health care[1], the major determinants of which range from the availability of health services to the quality and effectiveness of professionals and the

1 *The world health report (2000). Health systems: improving performance. Geneva, World Health Organization, 2000*

financial resources to access general and specialised care by patients[2]. Consequently, it is not surprising that policy makers, practitioners and other stakeholders in the global[3] health sector should be concerned about the growing disparities in health especially, despite the intervention efforts by governments.

Researchers show that health inequalities are determined by a range of social factors such as; race, education, ethnicity, gender, geographical location and income amongst others, and these factors reflect on and affect other components of a health system, resulting in poor health outcomes, mortalities and financial losses. This is observed more in Low and Middle Income Countries where life expectancy varies between 36 to 57 years compared to 80 years in high income countries. In South Africa, life expectancy at birth is 61 years (South Africa's life expectancy ranked 162 for females and 169 for males out of the 188 countries)[4]. Statistics reveal that health inequalities grew. This growth in health inequalities correspond to an increase in income inequalities. For example, income inequality in the country increased from 0.6 in 1994 to 0.679 in 2013. Of significance is the regional variation in health inequalities: for example, in the Western Cape Province where the white population in South Africa are mostly based, health inequalities and indeed income inequalities are stark.

Generally, South Africa has a population of 51.77 million made up of different peoples with varied cultures and belief systems. The 2011 population census indicated that of the total population, black Africans make up the majority (79.2%) at 41.9 million followed by coloureds whose population is projected at 4.6million, then the whites also make up 8.9% at a total of 4.5 million while the population of Indians and Asians is estimated to be 2. 5% of the general population at 1.3 million

South Africa is multilingual with over eleven official languages being granted legal prominence as follows-Afrikaans, English, isiNdebele, isiXhosa, isiZulu, Sesotho sa Leboa, Sesotho, Setswana, siSwati, Tshivenda, Xitsonga. Geographically, South Africa's land mass is considered to be nearly one third of the size of the entire European Union[5]. Economically, it is considered one of the fastest growing economies in the world by virtue of its gross domestic product and ranked the world's 26th largest economy. In 2011, the greatest contributors to the GDP by sector were; services (65.9%), industry (31.6%) and agriculture (2.5%). And, by 2012, Statistics indicated that the GDP grew at a rate of 3.2% with education and health being allotted one third of the total state expenditure[6].

Public expenditure on education in South Africa has been rated one of the highest globally and it is evident in the fact that education is mandatory for all citizens from seven to fifteen

2 *World Health Organization (2006). Quality of care: A PROCESS FOR MAKING STRATEGIC CHOICES IN HEALTH SYSTEMS. WHO, France*
3 *Howson C, Fineberg H, Bloom B (1998). The pursuit of global health: the relevance of engagement for developed countries. Lancet 1998351586–590.590*
4 *Statistics South Africa (2014) statistical release: Mid year population estimate-2014. Accessed 20/07/2015 available http://www.statssa.gov.za/publications/P0302/P03022014.pdf*
5 *opcit*
6 *ibid*

years of age or from grade one to nine. Available data from the 2011 census indicates that the ratio of those who have no formal education reduced from 17.9% to 8.6%. In terms of health expenditure, South Africa's is projected to be roughly 8.3% of GDP, slightly higher than the 5% endorsed by the WHO. Yet, inequalities in health persist and evident in health outcomes which are significantly poor compared to other developing countries.

Against this background, the aim of this paper is to provide an understanding of inequalities in health in the country. The paper provides a survey of empirical studies of health inequalities in South Africa with the chief aim of contributing to a comparative examination of social inequalities in health across different countries in Europe and other parts of the world. This paper puts findings from South Africa in context by comparing South Africa with Brazil and Europe in the hopes that doing so would improve understanding of determinants of health inequalities as well as provide insight on commonly used indicators. This review complements previous studies and adds to existing knowledge by providing easy access to a body of filtered and methodologically strong evidence of health inequalities in South Africa. By synthesising results of previous studies on health inequalities in South Africa, this review limits error and bias through identification and appraisal of relevant studies irrespective of design. Given the fact that this study forms part of a comparative examination of social inequities in health across South Africa and Europe (European Social Survey), it is intended to serve as a stock taking review relative to a comparison of inequalities in health among minorities in Europe and South Africa, for the shaping of the proposed study.

Therefore, it is my utmost intention that this review would help in determining what is known about health inequalities in South Africa as well as help in establishing knowledge gaps in existing literature. And, by comparing South Africa with other countries, identified gaps could be used oshape further research on health inequalities in Europe and other countries. Although studies have shown that social inequalities in health is widening across social groups and races in South Africa as a result of the apartheid legacy. However, South Africa is not alone in this. Most studies on health inequalities in multi-racial[7] and non-multiracial [8]contexts have also indicated similar findings[9]. When compared to Brazil and Australia, there is evidence that just like in South Africa inequality in health varies across geographical context and dimensions of social and economic class. National statistics suggests that in Australia, health inequalities are strongly linked with variations in access to education, living conditions in childhood, age, geographical location, ethnicity, race, socio-economic conditions and gender[10].

7 *Navarro V (1999) Health and equity in the world in the era of "globalization". Int J Health Serv 1999, 29:215-225*

8 *Kunst AE, Groenhof F, Mackenbach JP, Health EW: Occupational class and cause specific mortality in middle aged men in 11 European countries: comparison of population based studies. EU Working Group on Socioeconomic Inequalities in Health*

9 *Kawachi I, Marshall S, Pearce N(1991) Social class inequalities in the decline of coronary heart disease among New Zealand men, 1975–1977 to 1985–1987.*
Int J Epidemiol 1991, 20:393-398. PubMed Abstract OpenURL

10 *Public Health Information Development Unit (2010) Review of Health Status and Labour Force Productivity and Participation Data with Regard to Chronic Disease: Literature Review. University of Adelaide, Australia. [online] retrieved from: http://www.adelaide.edu.au/phidu/publications/2010-2014/health-status-labour-force-data-review.html*

Using a range of demographics and social indicators such as health status, disability and deaths; utilization pattern and provision of health and welfare services, studies have shown that in Australia, while the general wellbeing of the population is relatively high when compared to most countries, health outcomes and indicators vary across sub-groups and populations within the country, particularly, among the aboriginal and Torres Strait Island population. Akin to South Africa, socially excluded or disadvantaged populations in Australia, irrespective of age and gender were mostly associated with lower health outcomes, more likely to suffer frequent ill health, engage in unhealthy behaviour, experience poor health services utilization, less likely to utilise preventive healthcare.[11]

In Brazil, it is equally evident that social inequalities in health are comparable to that of South Africa. Demographically, both countries share similar characteristics history in terms of racial mix and history in the contexts of deprivation, stratification polarization and discrimination along racial/ethnic lines. While South Africa transited from apartheid rule to democracy in 1994, Brazil's transition from military dictatorship to democracy took place in 1988. Both countries transited into democracy as highly 'unequal' societies, scars from years of racial discrimination and legacies of inequities as a result of despotic rule. Just like South Africa introduced post-apartheid welfare, social grants and 'inclusion' sensitive laws to protect and cover previously disadvantaged population, Brazil introduced similar policies in its health system by focusing more on preventive care for all citizens and ensuring equitable access to health services. However, regardless of Brazils unified health system commonly known as S.U.S, which provides health coverage for all citizens, particularly low income earners, there is evidence of growing and persistent social disparities in health. And, these inequities are driven by educational attainment, race, socio-economic status, income and geographical location (rural-urban differentials and residential segregation based on class and earnings)[12]

For instance, an investigation of healthy life expectancy, deprivation and variations in life expectancy among men in urban Rio Janeiro, Brazil indicated that life expectancy at birth among males living in cosmopolitan and wealthier residential areas were by far higher than those of males living at low cost residential areas and shantytowns. Similarly, life expectancy among the elderly population (both males and females) was significantly higher amongst those from opulent backgrounds and rich sectors compared to the poor[13].These findings are consistent with studies carried out in South Africa given the

11 *Turrell G, Stanley L, de Looper M & Oldenburg B (2006) . Health Inequalities in Australia: Morbidity, health behaviours, risk factors and health service use. Health Inequalities Monitoring Series No. 2. AIHW Cat. No. PHE 72. Canberra: Queensland University of Technology and the Australian Institute of Health and Welfare*

12 *Frederico C G., (2010) Health equity in Brazil. BMJ 2010;341:c6542 doi: http://dx.doi.org/10.1136/bmj.c6542*

13 *Landmann C S., Corrêa da Mota J, Damacena G N, and Pereira T G,(2011) Health Inequalities in Rio de Janeiro, Brazil: Lower Healthy Life Expectancy in Socioeconomically Disadvantaged Areas. Am J Public Health. 2011 March; 101(3): 517-523. doi: 10.2105/AJPH.2010.195453*

fact the issues that characterise social inequalities in health in Brazil reflect the contrasts of wealth and poverty as well as other complexities of social inequalities in South Africa.

Part of discussion section

I hope that this review would contribute to an understanding of the determinants of health inequalities in multiracial, highly unequal and developing societies like South Africa. It is also anticipated that comparing social indicators between Brazil and South Africa would contribute to and help in giving further insights on the determinants of health inequalities as well as putting findings from this review in a proper context. For instance, Brazil and South Africa are rapidly growing economies, members of the BRICs and while South Africa is currently ranked as a country with the highest inequality indexes, Brazil is ninth most unequal country in the world with Gini indexes of 66.0 and 52.7 respectively[14]. Then again, in as much as South Africa and Brazil share certain similarities in terms of social indicators of health inequality such as self-reported risk factors, ill health, utilization pattern of health services and health behaviours, generally, there are explicit differences in terms of household income distribution where an average monthly household income for South African homes at R 2,400 was almost forty percent higher than that of poor Brazilians which is pegged at $100[15]. Sixty five percent of South Africans dwell in Houses while only 13.6% live in shacks. 77% of South Africans have access to water from regional or local service provider. 85.3% have access to electricity.65.8% of South Africans completed Grade 9 or higher.

Method

The method used for the review is essentially desk based with computerised search of Ebsco, Jstor, Medlink, Pubmed, google scholar, research.edu, Lancet, Riley, Uwc electronic data base, human science research council reports, Statistics South Africa, World Social Science report and other databases. Reference lists of included literatures were also searched for relevant information on evidence and determinants of health inequality in South Africa.

Inclusion criteria

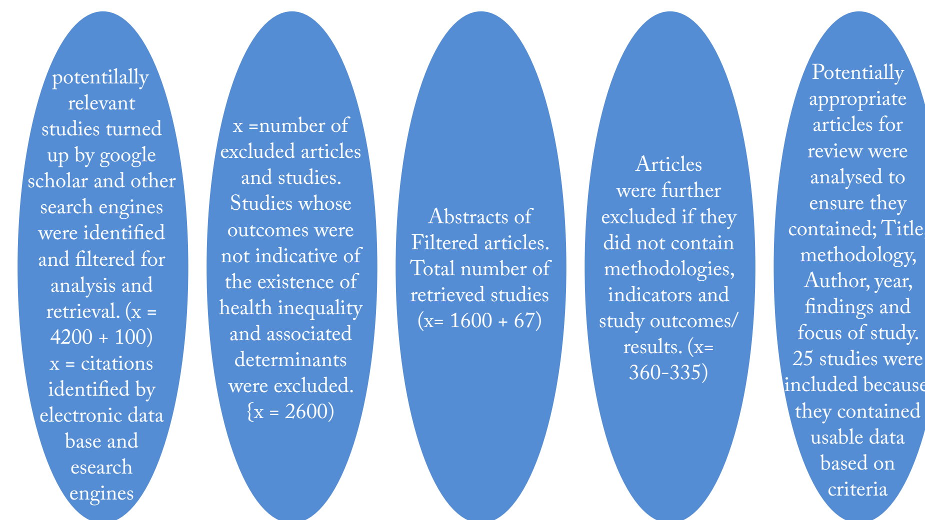
The review focused on searching for titles, abstracts, abstracts and body of peer-reviewed literatures published in 1994 to date using terms such as 'health inequity', 'health inequality', 'determinants of health', ' health inequities in South Africa', 'socio-economic determinants of

14 The World Bank. (2014) World Development Indicators.

15 See : Statistics South Africa : July 2015, South Africa Average Monthly Gross Wage. Retrieved from; tradingeconomics.com/south-africa/wages. Also, National Household Survey of the National Income dynamics study,(2008)

health inequality'. Other key words that were used to expand the inclusion list for relevant literatures during the search are 'inequality', health in South Africa, social exclusion.

Flow Chart



Flow diagram: showing the inclusion and criteria and details of how studies were retrieved, filtered and reduced to suitable sources.

Studies with a mixed population of all racial/ ethnic groups, various age groups, gender, income level, geographical locations (all provinces and residential areas) and socio-economic status were included in the search without language restrictions. Although selected studies had varying designs, methodologies and datasets; however, the focus was on outcomes that were indicative of the existence of health inequality and associated determinants in South Africa.

The search (conducted from June to November 2015) from the databases listed above turned up 4200 literatures. Out of the 4200 literatures, 100 were based on frequent citations. Out of those, 2600 were excluded because the outcomes were not indicative of the existence of health inequality and associated determinants. Abstracts of filtered articles were retrieved and most studies were further excluded because they did not contain methodologies, indicators and study results/outcomes. Out of the filtered studies, 335 were considered potentially appropriate for reviews. Further analysis was carried out to ensure they contained Title, methodology, year, authors, findings and focus of study. Out of that number, 335 studies were deemed appropriate but further excluded when findings and methodology as well as variables did not relate to health inequalities in South Africa. Out of the 335 studies that were considered usable, 275 had only abstracts

while the remaining 60 contained the full articles. Out of the 60 full articles that came up during the search for 'inequality' in South Africa, only twenty five original studies, using data sets from various yearly household surveys and World Bank data, met the inclusion criteria of 'health' inequality/inequity and determinants of health in South Africa. Total number of 25 studies were included because they contained usable and relevant information based on criteria (x=25).

Sub -thematic selection criteria (social indicators of inequality):

All selected literatures were subjected to sub-theme analysis based on their primary and secondary research findings/outcomes. Major themes used for sub group analysis included the following- health inequality induced or measured by race, ethnicity, adults, children; age; gender, socio-economic status; educational status; adult/infant mortality; employment status; living conditions; access to healthcare; use of health services; nutrition, hunger and access to food; electricity and clean water, living conditions, structural processes/ issues, geographical /residential location, urban-rural differentials and affordability of care.

After collating all relevant literatures based on the themes and inclusion criteria outlined above, in order to check for heterogeneity, the studies were further grouped into six categories for sub-group analysis;

a The first comprised original studies and literatures on socio-economic determinants of health,
b the second group was made up of studies that were based on paper/document review or policy analysis with historical dimensions of South Africa's apartheid legacy and evidence of post-apartheid health inequality,
c The third group comprised of studies that were related to access.
d The fourth group was made up of comparative studies.
e The fifth group included literatures that focused on the effects of migration on adult-mortality, morbidity and risk of diseases.
f While the sixth group comprised studies that focused on evidence of inequality among children; infant mortality and economic status, nutrition, underweight and stunted growth among children as measures of health inequality.

Results and Discussion

The results of the systematic review is presented and discussed in this section starting with a summary and the Table containing the reviewed literature.

Summary of Results

1994- Studies conducted within this period focused on race groups, presented summary and evidence of health inequalities

2002- 2003 - Focused on discussing socio-economic determinants of health inequality among various racial/ethnic groups. The second study also mentioned 'race' as determinant of health inequality in South Africa.

2006- 2007 – focused on migration and its effect on health inequality; analysis of World development indicators such as child and adult mortality

2008- Focused on social/inclusion policies; structural issues/ processes that exclude disadvantaged people (disadvantaged people here meant people of low socio-economic status); determinants of health and trends – analysis of socio-economic policies

2009 – Addressed mechanism that could be used in dealing with the inequities of the past (apartheid legacy); Mentioned race as determinant and suggested pro-poor policies such as child support and health care as the key mechanisms.

2010- paid attention to social exclusion as determinants of health inequality but did not really elucidate or give a precise definition of the 'socially excluded'; the second literature focused on age as a determinant of health inequality

2011- Focused on access to healthcare by analysing socio – economic status, race/ ethnicity, household disparities. Other studies conducted in 2011 tend to focus on socio-economic determinants of health inequality but then, specifically on 'race and ethnicity'. However, given the nature of the South African society, which is slowly dealing with the inequities of the past (a form of racial segregation known as apartheid that is characterised by a general economic binary of white as economically well-off and blacks /coloured/Indians as economically poor) black South Africans are majority numerically, but constitute low-socio-economic group, and the findings reflect their experience irrespective of whether they as in socio economic groups.

2012- Focused on evidence of health inequality among children

Table 1: Studies of health inequalities in South Africa

Author & year	Title	Focus of study	Methodology	Findings	comments
John E Ataguba James Akazili Di McIntyre (2011)	Socioeconomic-related health inequality in South Africa: evidence from General Household Surveys	Trend analysis of data which Investigates socio-economic related health inequality in South Africa; and tried to find out whether there has been a change in disease burden with regards to the spread of specific illnesses such as diabetes and other self-reported illnesses among socio economic groups and the extent to which there has been a change since 2000.	Analysed South African General Household Survey data from 2002, 2004, 2006, and 2008. In addition, standardized and normalized self-reported illness and disability focused directories were also used to evaluate the distribution of illness and disability across various socio-economic groups in South Africa.	The study indicates the existence of socio-economic inclinations in self-reported ill-health in South Africa. The burden of the major categories of ill-health and disability is greater among lower than higher socioeconomic groups. Non communicable disease such as diabetes and other disease considered disease of the 'rich' was evident among poor people. And, these poor people who are more likely to suffer more from violence and diseases do not have timely access to quality health care services.	The trend analysis used data from previous national survey and compared changes in disease burden and patterns among socio economic groups. (comparative) Due to lower earnings which tend to affect their access to quality health care, poor people are more prone to all kinds of diseases. Authors proposed taking inter sectoral action to tackle health inequity in South Africa.
Lungiswa L Nkonki, Mickey Chopra, Tanya M Doherty, Debra Jackson and Bjarne Robberstad (2011)	Explaining household socio-economic related child health inequalities using multiple methods in three diverse settings in South Africa	Focused on measuring *inequalities* in child mortality, HIV transmission and vaccination coverage among a group of infants in South Africa.	Used *decomposition* technique to Identify factors that determine inequalities in *'three'* child health outcomes. Also used *concentration index* to sum up inequalities in the three' health outcomes.	The study detected inequalities and significant differences in the availability of infrastructure amongst least poor and most poor families. There was also evidence of major disparities in all measured child health outcomes. Within same sample, it was observed that disease (HIV) transmission was higher among children from poor families compared to their more affluent counterparts. Notably, Immunisation Coverage was higher among the more affluent.	The observed inequalities were mostly due to the racial residential segregation and disparities in incomes. This shows that residential location and income affects and to an extent determines individuals and families ability to access health services. These factors also influence health seeking behaviour. In addition, black residential areas seemed to be mostly affected by poor socio-economic inequalities. While children who live under Poor socio-economic conditions have a higher tendency of being exposed to ill health and diseases.
Hall, K., & Woolard, I. (2012)	Children and inequality: An introduction and overview	Secondary data from various studies that had attempted measuring poverty and inequality	The study focused on various aspects of inequality among children in South Africa by first, delineating poverty and inequality, then went on to highlight a number of interconnected dimensions of inequality among children.	The study linked Health Inequalities in children to unfair living conditions and poor access to health services. The authors noted that the survival and development of children as well as their paths in life are influenced to a some extent, by their socio economic Statuses at birth coupled with the environments in which they grow up.	When compared, poverty is similar to inequality in the sense that it is structural and could be passed on from one generation to another in a family. In the same way, the apartheid legacy of health inequities has persisted despite efforts made by the government at providing social grants for the poor. These inequities could only be reduced if conscious efforts are made towards increasing school enrolments by disadvantaged groups.
INDEPTH Training and Research Centres of Excellence-INTREC (2007).	South Africa Country Report	Social determinants of health inequality – structural and economic drivers of health inequity and how Social determinants of inequalities are being taught in universities across South Africa.	The study used a review of curricula & literatures, as well as in-depth interviews with stakeholders across various sectors in South Africa. Also based on WHO Commission on Social Determinants of Health.	The review of university curriculum and interviews with various stakeholders across sectors indicated that inequities in the distribution of finances, power, and social-economic resources are the major determinants of health inequality in South Africa. And, these social factors appear to be the essential 'practical' drivers of the circumstances of daily living in South Africa and beyond.	The literature proposed that when there is improvement in the general conditions of daily life – such as those in which people are born, develop, live, work, and age, it would help in closing the gap in health inequalities.
Rispel LC1, de Sousa CA, Molomo BG (2009)	Can social inclusion policies reduce health inequalities in sub-Saharan Africa? A rapid policy appraisal.	A review of three categories of social inclusion policies (cash-transfers; free social services; and institutional arrangements for programme integration) that can impact on health inequalities in South Africa, Nigeria, Ethiopia, Botswana, Mozambique, and Zimbabwe.	Policy analysis based on the WHO Commission on Social Determinants of Health	The focus on South Africa analysed the effect of the country's pro-poor policies such as the child support grant and free health care on three things; *poverty alleviation*, *access to health care* and *economic opportunities*; and, how these inferred influenced health inequality. The review indicated that South Africa's free health care policy increased access to health care, Even though there was no mention of its direct impact on health inequalities.	The study was designed as a policy paper but did not highlight the impact of free healthcare policy on health inequality. The review indicated major weaknesses in policy design and implementation. Such as; enforcement, targeting criteria, and underlying costs, poor participation of communities, inability to take cognisance of cultural context, lack of a monitoring and evaluation system, with clear indicators that incorporate system responsiveness. Authors recommended that health inequalities be measured. Again, this points to structural issues as the core driver of inequality in out Africa.

J P Ruger and H-J Kim (2006)	Global health inequalities: an international comparison	Focused on gaps in the literature on health inequalities in work on inter-country inequalities, on the use of a threshold or norm (established by clustering techniques) and on the identification of "health gaps" for development policy purposes.	Data was analysed Analysis from the World Development Indicators 2003 database that was compiled by the World Bank. A systematic study of cross-national inequalities in adult and child mortality in order to classify mortality groups (most healthy, least healthy, mid-level health) through cluster analysis as well as survey risk factors associated with inequality in mortality	Bivariate and multivariate analysis indicated that all 9 countries that had high adult mortality and the 23 with high infant mortalities were located Sub-Saharan, Western Africa and Afghanistan. Bivariate analyses showed that comparative to countries with low infant mortality, those with high infant mortality had considerably higher rates of extreme poverty coupled with populations living in rural areas and female illiteracy.	Inequalities in child and adult mortality are global issues, huge, growing, and mostly linked with and highly influenced by socio- economic and health variables such as poverty, income, disease burden, living conditions, access to health services, etc.
Bradshaw D. (2008).	Determinants of health and their trends.	Reviewed post-apartheid determinants of health, and changes in health in South Africa.	The study used and analysed data based on a few governmental development reviews indicators such as: midterm development review indicators, the macro-social review; Statistics South Africa – StatsSA (1996 -2007 data) and South Africa Demographic and Health Surveys – SADHS.	Findings indicated general post-apartheid economic growth which was directly related to socio-economic policies and seemed to impact positively on living conditions by improving accessing to basic social amenities. Although, access to water, sanitation and electricity was relatively poor in certain parts of the country. Disparities in health were attributed to mainly to growing inequality in wealth in the country which also reflected in other aspects of life such as: food and hunger, living / working condition, education and social cohesion.	The study did not indicate how the economic growth impacted various social groups and the extent to which the living conditions of each racial / ethnic group were impacted by social and economic policies.

Rispel LC. MB, Dumel S. (2008).	South African case study on social exclusion.	The study focused on different concepts and policies of social exclusion; the effects of those ideas on well-being; as well as potential policies that could tackle the process of exclusion while reducing the inherent impact of inequality in health.	Qualitative method: informant interviews.	While a good number of social inclusion policies in South Africa focus on dealing with the legacy of apartheid, there is still evidence of growing inequities at both macro and micro levels which calls for a measurement of the exact scale of health inequalities in the country.	This study suggests that health inequality in South Africa is as a result of structural issues / processes that tend to exclude disadvantaged people. Social exclusion increases chances of people having higher health risks. Authors suggested further research and collective inter sectoral actions towards measuring the full scale and gradients of health inequality in South Africa.
Sartorius B, Kahn K, Vounatsou P, Collinson MA, Tollman SM. 2010.	Space and time clustering of mortality in rural South Africa (1992-2007).	Focused on examining causal risk factors for diseases	Health and Socio-Demographic survey.	Findings indicated that *social exclusion* was a major determinant of Health among the sample population. Migrants have a tendency to live far away from labour markets, healthcare facilities and without proper access to sanitation and electricity, hence, their living standard is relatively low and often results in poor health outcomes. Generally, adult and child mortality rates among immigrants(Mozambicans) was relatively higher than those of South Africans,	The focus here was on *Social determinant*s of health in rural areas. Excluded urban areas and did not highlight the cultural composition (black Africans, whites, coloureds or Indians) of the sample population. The study indicated that when compared to South Africans, migrants (Mozambicans) faced a higher health risks due to ethnic/ racial residential segregation which makes it difficult for most migrants to live close to social and health facilities. Immigration could possibly be a causal factor of poor health outcomes and in the long run, health inequality.
Welaga P. (2006).	The impact of migration on adult mortality in rural South Africa: Do people migrate into rural areas to die?	The link between immigration and adult mortality in South Africa.	Health and Socio Demographic Survey-HDSS	The study showed that Migration is a significant determinant of adult mortality. Findings showed that survey participants who moved from places outside the survey site surveillance area to seek residency in surveillance area (external migrants) faced bigger risk of death paralleled to those that were permanently resident in the HDSS survey site.	The study generally shows that short term migrants and people who migrated more often had a higher tendency of facing HIV related death than those residents who rarely migrated.

Clark SJ, Collinson MA, Kahn K, Drullinger K, Tollman SM. (2007)	Returning home to die: Circular labour migration and mortality in South Africa.	Migration and mortality	Survey	Short term migrants were more likely to die compared to long term migrants and Residents due to exclusion and adaptation processes.	Migrants face ethnic and racial residential segregation which could be associated with or considered a causal factor of racial health inequalities. South Africa is a country that is rich in diversity, and its diversity is visible in variations that cut across the following: Educational differences, ethnic differences, gender differences, urban-rural differences, class differences and age-group differences. And , these difference tend to affect socio-economically disadvantaged and excluded minorities rather than numerical minorities. surprisingly, numerically, black African descent south Africans are majority however, studies have shown that socio-economically, they are minorities and mostly affected by the structural legacies of apartheid which appears intractable despite government efforts.
Havenaar J, Geerlings M, Vivian L, Collinson M, Robertson B.	Common mental health problems in historically disadvantaged urban and rural communities in South Africa: prevalence and risk factors.	Assessment of the incidence and associated risk factors of mental health conditions in a sub-district and sub-urban location of Khayelitsha in the Western Cape province of South Africa.	Cross sectional study	Results from the study indicated that poor people (those who earn lesser income) and those with low educational qualifications faced higher risks of suffering mental disorder in the sub district (rural) of Agin-court, whereas, in the semi-urban location of Khayelitsha, unemployment particularly amongst females posed a higher risk.	The study formed part of literature on socio-economic determinants of mental health within a residential group in South Africa. Mental illness has been considered a factor of heal Here, Gender, income, educational achievement and economic opportunities were cited as the key determinants of mental health. And, mental health has been quoted as a common health disorder among social and economic minorities. This study raises valid questions about the possibility that residential segregation along racial / ethnic lines and economic status might be the major cause of ethnic / racial health inequality in South Africa. This is based on the fact that other studies have associated neighbourhood context with poor health outcomes and other health disorders which seem to be common among socially excluded groups.

Ng N, Kowal P, Kahn K, Naidoo N, Abdullah S, Bawah A, (2010)	Health inequalities among older men and women in Africa and Asia: evidence from eight Health and Demographic Surveillance System sites in the INDEPTH WHO-SAGE Study. Glob Health Action	This *comparative study among LMICs* uses international survey data to determine the full scale of *demographic* and *socio-economic variables* impact upon health measures in older people in Africa and Asia; To investigate gender disparities in health and possible explanations for these variations as well as how they could be ascribed to demographic and socio-economic determinants.	Longitudinal Analysis of Survey data using abbreviated form of WHO – SAGE (Study on global Ageing and adult health) Wave I instrument. Study population was a total of 46,269 participants; male and female adults, fifty years and above, whom were studied between 2006 and 2007. Measured variables: *self-reported health* and *functionality(sleep, pain and wellbeing)*, *life expectancy* and *disease / illness burden*	Generally, the study showed that Older men have better self-reported health than older women. There were visible variations in socio- economic factors such as: age, marital status, household socio-economic status, educational status and living arrangements. In addition, it was noted that various health fields such as pain, sleep and wellbeing contributed inversely to the general health ranking for men and women in each country.	The South African Survey took place at the Health and Demographic Surveillance Site at Agincourt and showed significant gender variations in terms of self-reported wellbeing. There were suggestions regarding further studies that could enable further understanding of other significant individual and contextual determinants to which the observed gender related disparities in health could be attributed to. This will lay foundations for an evidence based resource allocation and other health promotion programmes for older men and women in similar situations.
Bronwyn Harrisa, Jane Goudgea, John E Ataguba, Diane McIntyre, Nonhlanhla Nxumaloa, Siyabonga Jikwana and Matthew Chersich (2011)	Inequities in access to health care in South Africa	The focus was on exploring affordability, availability, and acceptability of health services.	Household survey using national data. Measured variables were: *health services utilization pattern*, self-reported *health status*, reasons for postponing or suspending health care, patients' opinions and experiences regarding health services, and health related expenses.	The study showed that Socioeconomic status, race / ethnicity, medical insurance status, and residential / demographic location (urban-rural) were linked with access to health care. Results further showed that of all those mostly affected by poor access to care, poor people, rural dwellers, uninsured and black Africans faced the greatest barriers access to care	Private spending (out of pocket) expenditures on health in South Africa is high among poor people. In addition, the existing information gaps regarding utilization payments and government policies seem to worsen 'access' challenges. When measured by health status, 'health needs' varied by gender, *socio-economic status*, and *residential location*. Perceptions of 'ill health' also varied among the rich and poor indicating that health needs were also influenced by socio economic factors which pointed out that while rich people might deliberately delay seeking healthcare, poor people were more likely to fall ill but generally constrained and unwilling to seek care due to associated costs and other limitations. Beyond race and gender, the study has highlighted the possibility of lifestyle and living conditions emerging as contextual determinants of health (risks) between the rich and poor.

Di McIntyre, & Lucy Gilson (2002)	Putting equity in health back onto the social policy agenda: experience from South Africa.	Focuses on stirring up debates around improvements in health inequalities reduction in South Africa, and also attempts to shape a general understanding and usage of the concept 'equity' in a comparatively limited manner.	Conceptualisation of concepts and analysis of policies and relevant 'equity and social inclusion documentations / literatures.	The study showed that the differences in human development in South Africa could be attributed to the apartheid legacy of racially inequitable socio-economic policies. In addition, post-apartheid, South Africa has made headway with social policies that could facilitate or constrain health equity progress- such policies include but not limited to: increased access to housing, water and sanitation services. The paper concluded that health equity goals are critically dependent on the central involvement of the dis-advantaged in decision-making about who should receive priority, what services should be delivered and how equity-promoting initiatives should be implemented	The study pointed out constitutional right to health, civil society activism; improved access to housing, water and sanitation as the major factors that would help in consolidating the gains of social policies that are meant to close the growing gaps in health equity. The study also alluded to the dominant role of the south African Socio-economic Structural processes; albeit, as a constraining factor; The argument has been that little effort has been made towards promoting cross-subsidisation between private and public health sectors. In addition, previous efforts made at encouraging coherency in social policies made no headway and appears to have fizzled out over time. On the other hand, some macro level policies at reducing budget deficits by the government has been accused of destabilizing equity promoting social policy enterprises.

Benatar S (2013)	The challenges of health disparities in South Africa	The socio –economic factors that influence health in South Africa.	Policy analysis- National Health Insurance.	The key determinants of an individual's health start at the mental, physical and nutritional wellbeing of the pregnant woman at conception and childbirth then continues throughout the life span of the child. Maternal literacy and wellbeing influence the socio –economics status of the child and contributes in a great measure to improved access to nutrition, sanitation and better housing and living conditions which are factors that improve or limit good health outcome. Although living conditions have improved reasonably since the end of apartheid in 1994, free market structure and *rapid urbanisation* has resulted in the *migration* of human resources for health to metropolitan cities and urban areas. In addition, structural anomalies such as corruption, poor resource allocation, lack of synergy between public and private health sector; poor management of public health services have extended health and income disparities.	Health inequality in South Africa was highly influenced by racial residential segregation and differed by race/ ethnicity as well as geographical region. e.g while Kwazulu Natal had higher mortalities, western cape province had lesser. Within western cape province, while those in the metropolitan suburbs had relatively lower mortalities, the people in Kyhelitsha a sub district, had higher mortalities. Between 1994 and 2008, Black Africans recorded poorer health outcomes (higher mortalities) compared to whites and Indians.

Community Agency for Social Enquiry (CASE) & Henry J. Kaiser Family Foundation. (1994)	A National Household Survey of Health Inequalities in South Africa	This national survey focused on assessing the extent of health inequality and progress made in reducing determining factors post-apartheid by evaluating the following aspects of health; : Demographic data, child and reproductive health, barriers to healthcare, quality of healthcare, satisfaction with healthcare, Public Health Situation, Site of Care, Chronic Health Conditions.	National household survey.	When compared to whites and Indians/Asians, black African population in South Africa suffered the highest form of socio-economic deprivations. The high level of depravity among the black African population was evident in the following variables ;Poverty, public health conditions, living conditions such as housing, sanitation and access to drinking water. Overall, poor living conditions and poor public health made black Africans most vulnerable to ill health resulting in higher mortalities. The study found that physical and emotional health are thoroughly interwoven; individuals who were unhappy or worried about their socio –economic status/ wellbeing were more likely to suffer anxiety, depression/ mental health disorders and poor health compared to those who were satisfied with their socio-economic status. Furthermore, the study showed that amongst whites, irrespective of their residential or geographical location, there was minimal variation in access to health care, or utilization patterns. However, majority of the black African population and Indians who lived in Kwazulu Natal, Eastern Cape and other rural/ majority non-urban areas had higher poverty level and poorer access to social amenities and health care.	Out of three black Africans, one lived in the rural areas, in informal locations within urban areas or on white owned farms where timely access to health services and amenities are relatively challenging compared to other social / racial groups. South Africa is made up of 70% Black Africans, 7% coloureds, 20% whites and 3% Indians. And, of the total sum of black Africans, 54% live in rural areas, former homelands or white owned farms and use public health facilities' facing constrains such as long distances, lack of transportation and lack of health insurance. While, on the other hand, whites and Indians live in metropolitan areas, closer to amenities and use private health facilities, sometimes subsidised by employers and the government. Consequently, the wages of the majority black Africans reflect in their choice of residential locations; poor living conditions, access to amenities, health and social services as well as the resultant poor health outcomes. Furthermore, while *living conditions* are determined by race, income and educational attainment, access to healthcare is further influenced by race, income, gender and socio-economic status. Beyond race and income, the biggest determinant of health inequality and residential location was educational attainment. Black African households who had 'heads' with higher degrees were more likely to earn higher and live in better neighbourhoods than those who had lesser degrees but earned much more than the minimum wage. 70% of black African children live in rural areas and face tougher socio economic challenges at birth compared to whites and Indians who are born with better opportunities (this trend has been named as one of the legacies of apartheid). Among the older population, Black Africans and coloureds were more likely to suffer decline in health and mental health issues associated with apartheid compared to whites.

StasSA (2011)	Use of health facilities and levels of selected health conditions in South Africa	Health related aspect of a general household survey in South Africa	General household survey made up of mostly qualitative interviews of 25,000 households of all races / ethnicities in South Africa.	There are significant variations in access to healthcare among various racial groups in South Africa. Access and quality of care varies not just by race but by provinces(geographical and residential location While households in the Western Cape province tend to have easier, faster access and quality healthcare, those in Kwazulu Natal had a higher probability of experiencing longer waiting times and better services compared to those in the non-urban and poor province of Eastern Cape who can barely access quality healthcare due to poverty and poor access to infrastructures.	This study corroborates previous studies from CARE- majority of black African South Africans and coloureds live in areas and provinces where access to health and amenities remain a challenge years after apartheid. When compared to whites, Indians and coloureds who lived in Kwazulu Natal and Western Cape either lived close to amenities, have better means of transportation, medical aid and when they do not live closer to amenities, can afford health/ social services from the private sector.

Wadee, H., Gilson, L., Thiede, M., Okorafor, O., & McIntyre, D. (2003).	Health care inequity in South Africa and the public/private mix	The study summarises post-apartheid health policies by analysing health inequality in South Africa, within the context of specific public private synthesis in health care. In doing so, it identifies various apartheid legacies of health inequality that that are intractable and evident in the health status of citizens and unequal access to health care.	A national household survey with focus on use of healthcare across public and private sectors. Data for the survey was collected yearly between 1993 and 1999 by Statistics South Africa (StatsSA);	Data analyses indicated that the most prominent determinants of health and health inequality post-apartheid are; race (Black South Africans and to a minimal extent coloureds); gender (particularly, female headed households); age; educational attainment, economic or employment status; access to food and nutrition; living condition such as housing, sanitation, access to electricity; access to safe/clean water and sanitation; educational status; residential and geographic location; disintegration of the family and labour related migration.	A comparison of health outcomes relative to income flow across all racial/ ethnic groups in South Africa indicated that although the private sector currently plays an important role in the South African health system, most service providers and medical insurers in that sector still live out the country's apartheid legacy by directly or indirectly serving a particular racial (whites) and socio economic (higher income earners) groups, to the detriment of low income earners who are mostly black African population and tend to utilise and patronise the public sector more often. Users perception of general healthcare services in South Africa reflects that the health system is polarised along racial/ethnic lines where black Africans and coloured tend to use public health sector more frequently compared to Indians and whites who prefer the private sector. The racial/ethnic divides are traceable in and tend to influence other socio economic aspects such as income, residential locations. Health inequality as evident in utilization pattern (mostly of private sector) by race/ ethnicity declined as income and educational status improved. Living condition, social cohesion and food security by race/ethnicity subsequently improved significantly, especially for black African and Coloureds, as employment status improved.
Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009).	The health and health system of South Africa: historical roots of current public health challenges.	A report that focuses on analysing social and health policies in South within a historical epoch.	Review of past health policies and documents using the following variables – HIV / AIDS, TB, Violence, Maternal health, child health, non-communicable diseases and injury across various racial/ethnic groups.	Racial and gender discrimination, the migrant labour system, the destruction of family life, vast income inequalities, and extreme violence have all formed part of South Africa's troubled past, and all have inexorably affected health and health services	The report presented historical dimensions of racial and gender inequalities in the country as well as associated macroeconomic and socioeconomic milieus of health Once again, there is an allusion to structural processes and apartheid legacy as fundamental determinants of health inequality in the country.

Hirschowitz R; Orkin M; de Castro J; Hirschowitz S; Segel K; Taunyane L (1995)	Examines healthcare inequalities in South Africa.	a 1994/5 survey of health inequalities.	The study used data from a nationally representative survey that was conducted in 1994 among 4000 households.	Findings suggest that the black South African population in South Africa were mostly affected by inequalities in health with evidence from factors ranging from 'poor public health conditions, difficulties in accessing health services, and ill-treatment during health service provision'. A great majority of the Black South African population were affected by poor access to toilets, safe/clean water, sanitation, lack of electricity and overcrowding compared with Indians and Whites who had close to zero incidence of poor access to tap water. With regards to income, majority (66%) of white families earned incomes that was above R2000 compared with ¼ of the Black African families that earned average monthly income of R300 which is considered abysmally lower than the minimum living level of R900. While black south Africans tended to use public healthcare facilities and private doctors, unlike other racial groups, they were mostly affected by a number of barriers to access such as distance, hospital fee / affordability and transportation constraints like poor accessibility and high cost. While outreach services was generally poor for all racial/ ethnic groups in the country, black South Africans, children, rural dwellers, low income earners, and unemployed people were mostly affected.	The study focused on assessing selected determinants of health inequality across all racial/ethnic groups such as *health, maternal / reproductive health, infant health, barriers to care, health centres, public health conditions, quality of health care, patient- satisfaction with services, chronic health conditions.* The study contradicted other studies that suggested that black south Africans seldom used private doctors. Perhaps, this new development might be associated with the BEE policy. Findings suggests that 70% of African children lived in rural areas, 66% did not have birth certificates, 75% lived in families whose incomes were below R900

Maureen Mackintosh	Health Care Commercialisation and The Embedding Of Inequality	Systematic observations of the impacts of globalisation on poverty, inequality and systems of social protection; comparative study of Mali, South Africa, Vietnam, Bulgaria and Switzerland. The study also focuses on exploring the extent of Commercialisation of healthcare and how this is and examines its associated with Inequality in income and health.	Case study - Comparing five countries. Using available data The following variables on globalisation and inequality were measured; Health, Education, Income inequality, economic development, political economy, social development and social Protection/pensions.	The study did not provide detailed analysis of research results by country. However, findings showed that the south African health system is divided along racial and economic lines where the rich which includes most of the white population have medical insurance cover and can afford private sector services whereas, the poor and mostly black Africans and coloureds do not have medical insurance therefore, are forced to seek care in public sector or made poorer by the highly regressive payment system of the private sector. 'the commercialization of healthcare has led to institutionalisation of segregated health care provision which reinforces social division while worsening health differentials among populations'.	The study examines the burdens and effects of for commercialisation in health care health care by concluding that in increases health inequality. Within the context of health inequality, the challenge of affordability is worsened by Commercialisation and hinders and in some instances impacts negatively on social cohesion.
Gavin Mooney and Lucy Gibson	The economic situation in South Africa and health inequities				

Eyob Zere and Diane McIntyre (2003)	Inequities in under-five child malnutrition in South Africa	The study focuses on quantifying health inequalities in South Africa by measuring the scale of inequalities in malnutrition of under-five kids that are attributable to socio-economic status. It evaluates and enumerates the extent of socio-economic related disparities in under-five child malnutrition in South Africa.	Data on the sample population (3765 under-children) was collected from the Living Standards and Development Survey in South Africa. The socio-economic status of households was measured using *household expenditure.* While inequality in malnutrition was measured using *residential or provincial residence*. The survey was conducted jointly by the South African Labour and Development Research Unit (SALDRU) and the World Bank in 1993 based on a sample of 8,848 households which was made up of 40,284 people.	Results showed that stunting was the commonest form of malnutrition across all social groups in the Country but highly prevalent among under-five children in provinces (Eastern Cape & Northern Cape) with higher rates of poverty. However, while no form of inequality or malnutrition was detected among White children across all provinces/ residential locations, a measure of underweight and stunting was found amongst coloured children and in metro (Western Cape and Gauteng) residential locations. Across all provinces / residential areas, malnutrition which is an indication of health inequality favoured the rich and children from well off families than those from disadvantaged backgrounds.	This study confirms findings from the 1994/95 survey by CARE on behalf of Kaiser family that health inequality in South Africa is determined by provincial and residential locations. Residents of poor, mostly non-urban and rural provinces are more likely to suffer poor health and health inequality than those of same race and socio-economic status living in richer and more urban provinces. The study also validates previous studies that major variables associated with health inequality such as malnutrition and stunting diminish significantly as a family's income or socio-economic status increases. There is evidence of Socio-economic inequities in health across all age groups, with the probability that childhood inequalities may likely continue in adulthood. Twenty years after the apartheid rule, black South Africans and coloureds that were considered historically most disadvantaged are still utterly disadvantaged with appalling evidence in the wide income inequities and residential segregation between them and whites, as well as high rates of stunting / underweight in rural than in metropolitan areas and rural-urban income differential.
Eyob Zere (2002)	Addressing health inequalities in South Africa : policy insights and the role of improved efficiency	Empirical assessment of the existing state of health inequality and trends with regards to infant mortality, self-reported illness, disease and use of various service providers in adulthood.	Survey and analysis of secondary data collected from the Living Standards and Development Survey (LSDS) of 1993, annual statistical publications of provincial health departments and October Household Survey (OHS) series (OHS 1995 and OHS 1998) that are conducted annually by Statistics South Africa.	Study showed that membership of a white household and living in the rural area affected Infant mortality and morbidity rates. The study also showed that mortality and morbidity rate was significantly higher among Black African infants.- children living in rural areas recorded higher incidence of ill health and death compared to those in urban areas and those from white families. Infant mortality decreased as household income increased.	The study and analysis was based on old data that was collected in 1993. There is possibility that the data may have changed and not totally descriptive of the investigated variables. This study upholds findings from other studies that geographical area and race were the fundamental determinants of health inequality in South Africa, outside gender and income.

Studies of Health Inequalities in South Africa: Overview

In South Africa, inequality is greater today than at the end of apartheid, Oxfam (2014). Studies by the World Bank (2012) have shown that health inequalities in SA are influenced by various factors such as educational level, income, race, gender, geographical or residential location and these factors vary among different age groups and geographical location. Agatuba et al (2011) and Gakidou (2000) defined health inequalities as the variations in health status across individuals in the population. Regardless of the operational definition or dimensions of analysis, inequality remains one of the most debated issues on the South African socio-political agenda and one that draws attention to the Country's economic growth which apparently has not impacted much on the welfare of the people. Inequalities in health has been associated with a broad range of poor health outcomes for minority, socially excluded and disadvantaged groups[16]. High mortality rates, poverty and race have also been mentioned as some of the common issues associated with variations in health among various socio-economic and racial/ethnic groups in South Africa.

What is evident in the literature is that the end of apartheid in the 1990s saw the introduction of a dispersal system where the health system was overhauled to close the inequality gaps in the distribution of health/social services and resources. However although these system reforms and introduction of primary health care may have made inroads in some aspects, it has been associated with disparities among previously disadvantaged people and highly regarded as the intractable legacies of the apartheid rule[17].

Other studies[18] examining post-apartheid poverty and inequalities in South Africa among racial/ethnic population also reported a high level of income inequality at the racial / provincial level, particularly among black South Africans and Western Cape coloured population[19]. These studies suggested that health inequalities, low access to healthcare services, income inequalities and poverty among the black population and coloureds in the country were increasing at an alarming rate and had prevailed given the fact that post-apartheid government in South Africa focused more on increasing the country's GDP(economic growth) rather than taking pro poor income redistribution measures

Even though the reasons for the prevalence of health inequities among previously excluded people (black South Africans) remain poorly understood, some studies have attributed it to structural processes while others suggested that at birth, most blacks are born without economic opportunities[20]. It has been hypothesized that governance deficit, the structure of the South African health system; provincial healthcare stewardship, policy implementation and financial management are significantly associated with health inequalities sin the country. A similar position has been adopted by Gelb (2003)[21]& Coovadia et al (2009)[22] which suggests that health inequalities in South Africa could be traced to governance deficit and apartheid polarization of the country along ethnic and racial lines which post- apartheid government had failed to adequately address. Coovadia et al suggested that post-apartheid government was weak and often executing poor policies that have led to the implementation of macroeconomic policies and the promotion of economic growth rather than redistribution, thereby contributing to the persistence of fiscal inequalities among racial/ethnic groups even with increases in social grants.

Another study suggested that ideological supports, systemic lapses, health sector structural conditions and weak policies have deepened health inequalities resulting in provinces with white majority receiving more healthcare funding and having better access compared to provinces with black majority where access to health services are generally inadequate[23]. Stuckler et al (2011) revealed that provinces with better spending capacities are more likely to receive funding than those with greater disease burden/ health needs given the fact that those who spend their budgetary allocation tend to build more infrastructure and often have tangible output to show for the expenses.

Another researcher argued that inequitable disbursements and expenditure patterns compared to health needs as well as operational inefficiencies and shortage of bio medical personnel in public health facilities have aggravated health inequities in the country, Harrison (2009)[24]. Considering the hypothesis that the South African health system funding is tilted in support of provinces/regions with absorptive spending capacities (an apartheid legacy), it would not be out of place to suggest that the general structure of the health system could likely be the core driver of health inequalities in the country.

While most of the hypotheses presented above were based on thorough analysis of imprecise health-related indices and policies, The 2008 NDIS survey provides a report similar to most of the expressed hypothesis and positions. The study reported that 45% of black South Africans did not have satisfactory healthcare coverage, whereas, only 19% whites had inadequate coverage. A similar submission by Gradin (2013) agrees that years after apartheid rule, the percentage of blacks who lived in deprivation was far greater than whites. For instance, 30% of black South Africans in 2008 lived in informal residences, 47

16 *Van Rensburg, H. C. (2014). South Africa's protracted struggle for equal distribution and equitable access–still not there. Hum Resour Health, 12(26).*

17 *Ronelle B, Caryn B, Christelle G, Servaas B (2012) Have public health spending and access in South Africa become more equitable since the end of apartheid? Development Southern Africa Vol. 29, Iss. 5, 2012*

18 *Zeida R. Kon and Nuha Lackan. Ethnic Disparities in Access to Care in Post-Apartheid South Africa. American Journal of Public Health: December 2008, Vol. 98, No. 12, pp. 2272-2277.doi: 10.2105/AJPH.2007.127829*

19 *Özler, B. (2007). Not separate, not equal: poverty and inequality in post-apartheid South Africa. Economic development and cultural change, 55(3), 487-529*

20 *Woolard.*

21 *Gelb, S. (2003). Inequality in South Africa: Nature, causes and responses. Edge Institute.*

22 *Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: historical roots of current public health challenges. The Lancet, 374(9692), 817-834*

23 *Stuckler, D., Basu, S., & McKee, M. (2011). Health Care Capacity and Allocations Among South Africa's Provinces: Infrastructure–Inequality Traps After the End of Apartheid. American Journal of Public Health, 101(1), 165–172. http://doi.org/10.2105/AJPH.2009.184895*

24 *Harrison, D. (2009). An overview of health and health care in South Africa 1994–2010: Priorities, progress and prospects for new gains. Washington, DC: Henry J Kaiser Family Foundation.*

% did not own refrigerators, 34% did not have television, 32 % did not own radios while 2/3 did not have access to pipe borne water in their homes and sourced water outside, compared to 5.5% of whites who lived in informal settlements, 6 % did not own television, 7% did not have refrigerators while 18 percent did not own radios. Generally, fewer than 2% of whites did not have all three of these appliances in their homes; while12% of Black South Africans lacked the three appliances. These figures by Gradin (2013) sum up the determining factors of health inequalities in South Africa as evident from previous studies which subsequently prompts the question of how these results from South Africa compare with results and statistical indicators from other regions like Brazil and Europe?

Comparing health inequalities in South Africa, Brazil and Europe:

Health inequalities are determined by a range of social factors such as; socioeconomic status, race/ethnicity, education, gender, geographical location and income amongst others, and these factors reflect on and affect other components of a health system, resulting in poor health outcomes, mortalities and financial losses: As such, becomes a concern of global, regional and national policy makers and agencies implementing health related projects and actions. However, even though there is a growing body of evidence documenting inequalities in health distribution and access to health services in South Africa, there seems to be no consensus on what the major social indicators and determinants of health and access to health care should be[25]. Besides, even though a number of studies present comparative analysis of health systems, there is limited cross-national analysis and systematic reviews of health inequalities in high and medium income countries. Consequently, in order to identify, pre-filter and document evidence of health inequalities, major determinants, similarities and differences among various populations and groups in high versus middle income countries, this section of the paper will compare health inequalities in South Africa, Brazil and the EU member states.

Although this review will not pay particular attention to the comparison of ethnic majorities versus minorities in South Africa, Brazil and EU, the follow up to this (proposed ESS study in South Africa) paper would be operationalised thus: The comparison would be between black South Africans as the majority versus Asians, Whites, Indians, and African immigrants as minorities. In the EU, the comparison would be between indigenous Europeans as majority and immigrants as the minorities. The study would also present detailed analysis of all ethnic and minority groups in SA and immigrants in the EU for a comparative understanding of existing health disparities within the minority groups and possible explanations for such variations.

Although there have been improved international, regional and national level policies aimed at closing the inequality gaps in health between 2000 and 2014, World Bank

25 De Maio F, (2007) Income inequality measures. J Epidemiol Community Health. 2007 Oct;61(10):849-52. Review. PMID: 17873219 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652960/

statistics show that income and health inequalities in South Africa and Brazil remain one of the highest globally[26]. For example, large percentage of the majority of the population (mostly black) in South Africa still does not have access to health services twenty years after the apartheid rule. Similarly, despite the notable and outstanding success rate of Brazil's national health system, Sistema Unico de Saude-SUS, majority of Brazils rural population do not have access to health services and medicines[27].

In addition, just as health inequalities statistics in SA differs across geographical provinces, the same holds in Brazil. In the predominantly white Western Cape Province (mostly urban and richer) of South Africa, maternal mortality figures reflect 27 per 1000 births while in the predominantly black Eastern Cape (mostly non-urban); the figures are 70 per 1000[28]. Similarly, in Brazil, the North east has extreme levels of poverty coupled with stunting in children and high infant mortality ratios while the mostly urban areas of south and south east Brazil recorded lower mortality ratios and stunting in children[29]. Just like in South Africa, inequalities in health in Brazil are driven by factors such as socioeconomic status, living conditions, ethnicity, geographical location and gender. In both countries, poverty, income, residential segregation (for people living in same province), geographic location (rural-urban differentials) educational status, health insurance, gender, and socio-economic condition at birth contribute in great measures to inequalities in health[30].

Generally, inequalities in health in both South Africa and Brazil tend to be more prominent at the secondary and preventive care level given the fact that both countries operate pro-poor health systems where primary care is universal and free at public facilities, making it easier for low income earners to gain access to care. Yet, in terms of secondary care, long waiting times, delayed consultation with bio medical personnel and lack of health insurance contribute to inequities experienced by low income earners at this level. Furthermore, while most low income earners in both countries have low access to health insurance, research has shown that they have greater need for healthcare and ironically, lesser access to and utilization of healthcare services[31].

Apart from Brazil and South Africa, inequities in access to healthcare keeps widening, affecting health outcomes globally, even in developed countries[32]. Beyond its effect on

26 World Bank (2014) World Development Indicators.

27 Ingrid V., Amparo S., Garcia-Subirats I., Ferreira da Silva R., De paepe P., Borrel C., and Jean Pierre U., (2014) Inequities in access to health care in different health systems: a study in municipalities of central Columbia and North-eastern Brazil. International Journal for Equity in Health 2014,13:10. Doi:10.1186/1475-9276-13-10

28 Human Rights Watch. "Stop Making Excuses." Accountability for Maternal Health Care in South Africa. Johannesburg: Human Rights Watch. http://www.hrw.org/reports/2011/08/08/stop-making-excuses

29 Opcit'

30 Pinheiro R., Viacava F., Travasco C., Brito A., (2002) Gender, morbidity, access and utilization of health services in Brazil. Cien Saude Colet 2002,7(4):687-707.

31 opcit

32 Van D., Masseria C., Koolman X., (2006) Inequalities in access to medical care by income in developed countries. CMAJ 2006,174(2):111-183.

health outcomes, inequalities account for over one third of the world's urban population living in slums and poor conditions. In financial terms, in the European Union as a whole, health inequalities-related fatalities account for more than 700,000 deaths annually, and over 33 million dominant cases of ill-health[33]. While inequalities related losses have led to financial and resource damages in the EU to the tune of nine hundred and eighty billion euro (€980 billion) per year. Additionally, when valued as consumption good[34], the losses are evident in taxes and loss of productivity due to ill health, which are estimated at 9.5% of the annual GDP in the EU.

Throughout low and middle income countries, life expectancy varies between 36 to 57 years, whereas in high-income countries, it is 80[35]. Generally from 2000 to 2010, inequalities in life expectancy at birth amongst EU countries diminished by 10 % for women but only by 3% for men. Correspondingly, infant mortalities reduced between EU countries and same in South Africa. Yet, other dimensions of health inequities such as income and educational levels keep increasing across borders, within countries and amongst ethnicities/sub populations.

A World Bank report[36] published in 2012 on health inequalities in SA revealed that the variances in life opportunities for children in South African were largely due to factors that range from household income, gender to location and race. Likewise, a 2013 study revealed that across the EU, and in virtually all member countries, the self-reported level of health was worse for those with lesser income and educational levels than those with high incomes and education[37]. These figures reflect widening health inequalities in SA and the EU that could be traced to socio economic factors although the exact scale and reasons for these disparities has not been accurately estimated particularly among minority groups.

Determinants of health inequality in South Africa

The evidence of health inequality and determinants of health inequality among minority groups in South Africa was investigated in 25 existing literatures. Of all analysed literatures, provided evidence of health inequality in South Africa; seven studies discussed and analysed historical dimensions of health inequality in South Africa; two studies examined the effect of migration on adult mortality; an additional two studies examined

33 *Mackenbach JP. (2006)Health inequalities: Europe in profile. London: Department of Health.*

34 *Mackenbach J, Willem J, Anton K (2007) Economic implications of socio-economic inequalities in health in the European Union. Published by European Communities*

35 *World health organization" Fact file :10 Facts On Health Inequities And Their Causes" http://www.who.int/features/factfiles/health_inequities/facts/en/index9.html*

36 *W orld Bank, (2012). South Africa Economic Update: Focus on Inequality of Opportunity. World Bank, Washington DC.*

37 *European Commission (2013). Health inequalities in the EU — Final report of a consortium. Consortium lead: Sir Michael Marmot. Published by the European Commission Directorate-General for Health and Consumers. ISBN 978-92-79-30898-7 doi:10.2772/34426 http://ec.europa.eu/health/social_determinants/docs/healthinequalitiesineu_2013_en.pdf*

health inequality among children; another two studies were comparative studies of South Africa and other countries in Asia and Europe (Bulgaria and Switzerland) while eleven studies examined the socio-economic determinants of health inequality in South Africa.

Of the eleven studies that addressed socio-economic determinants of health, nine analysis reported that infant /adult mortality, self-reported ill-health, disease burden, use of health services, geographical/residential location, race, public health condition, living conditions and income were associated with and highly influenced health. Of these eleven studies, seven analyses found that out of all racial/ethnic groups, black South Africans, uninsured people, females, children, rural/non-urban dwellers, residents of poor provinces/neighbourhoods and unemployed people were mostly affected by the determinants of health. While all the studies found a significant association between the socio-economic statuses of black South Africans with health inequality, two analyses found a minimal association between the health of coloureds and residential location (within the metropolitan areas); two analyses found imprecise association between the health of Indians, geographical location and use of health services, while no form of inequity was observed among whites of all ages and gender living in Gauteng and other provinces.

Two studies suggested that race, educational status and gender significantly influenced access to and use of health services which were used as measurable dimensions of health inequality in those studies. Only one study submitted that race and socio-economic conditions of the mother during pregnancy and the child at birth could influence health in adulthood. Thus, evidence of health inequality and socio-economic determinants of health were obvious.

The evidence of health inequality and its determinants in South Africa were the focal points of this study. And, given the apartheid legacy of inequities in income distribution and dispersal of social infrastructures in the country, two analyses attributed growing inequities in health to income inequality which is associated with the free market policy of post-apartheid government; Van et al (2014). This free market policy has been accountable for widening inequities in income within racial groups and has ultimately rubbed off on health, thereby, necessitating timely interventions in the form of pro-poor policies.

Generally, the methodologies of all included 25 literatures differed given the fact that they studied different variables. However, the outcomes and findings presented, indicated similar evidence and consensus on the existence of health inequality in South Africa, post –apartheid. For example, Hirschowitz et al (1995) assessed selected variables that are descriptive of inequality and found evidence that Black South Africans were still marginalised in terms of access and use of healthcare services. In all studies, morbidity, self-reported ill-health of selected health conditions, living conditions, race, income and geographical locations featured prominently, however, neither of the studies delved deeper into the causes of all self-reported health conditions noticed in all social/racial groups. For instance, Ataguba (2011) observed that there was prevalence of stroke and diabetes (disease of the affluent) among poor people but did not provide further

explanations for this incident among poor people who are mostly black South Africans.

Results from all studies could not be pooled based on the fact that the study designs and sample populations differ significantly. Moreover, the use of various variables as dimensions of health inequality presents a core challenge in measuring health inequality among minority groups in South Africa given that fact that observed indices in one social/racial group might be different and not visible in another racial group. Although there was consensus regarding the existence of health inequality and its social determinants in South Africa, fitting the variables used in original studies was quite challenging since methodologies and datasets differed greatly and could hardly be quantified.

Given the fact that only literatures and articles which mentioned health inequality and factors that influence inequities in health in South Africa were selected, it limited the scope and sample size. While this review applied a rigorous selection / inclusion process, the major limitation is the fact that due to time constrain and protocols regarding copyright/ permission for use of most print materials, most print materials and unpublished national surveys within the context of health inequality were excluded.

Out of all the studies, the most frequently cited determinants of health were race, structural processes, poverty, income and geographical /residential location. In addition, gender, employment opportunities, socio-economic status, educational attainment, living conditions and medical insurance were mentioned. A regression analysis of studies revealed significant differences of ($p< 0.01$) in terms of selection of variables and methods as well as several perspectives on determinants of health inequality in South Africa. However, in spite of the heterogeneity across studies, the combined agreement/consensus on the evidence of widening health inequality among (previously excluded or disadvantaged) black South Africans and poor people was 88%.

An evaluation of research methods, study samples and variables indicated that geographical location was significantly associated with health. However, 30% of the studies that were specific to particular provinces or conducted in the rural areas did not have the right mix of all racial/ethnic and socio-economic groups. Only those studies conducted with national data could perhaps, be said to have representative samples of all racial/ethnic groups. Most of the studies ignored rural-urban differentials in their conclusions and this factor alone, was considerably associated with the variability of health inequality among people of same race/ethnicity (blacks, coloureds and Indians) except whites.

Literatures that focused on analysis of policies and policy documents from 1994 till early 2000s found significant association between redistribution of wealth, social grants or increased income with variables like race, living conditions, sanitation, malnutrition (underweight, stunted growth), hunger, gender and age. Surprisingly, studies conducted in the context of policy analysis related, without clearly defined variables and sample population were significantly associated with determinants of health inequality among poor people, older people, children and women.

Neither studies using previously collected yearly national survey data or those using World Bank data revealed significant variances in their results. Studies using national survey data from 1994 to 2003 were significantly associated with socio-economic determinants of inequality while those from 2006 till 2014 indicated higher association with emerging trends (such as access to healthcare, mortality rates and prevalence of diseases among adults and children of all races/ethnicities) and the role of social processes as drivers of health inequality in South Africa.

Geographic location / racial residential segregation were also linked with major differences in health among black South Africans resident in Gauteng / rural or non – urban areas and that of coloureds in the Western Cape and those in other metropolitan suburbs. There were significant variations in health and socio-economic determinants or Estimates from blacks and coloureds that had lived longer or permanently in urban areas than those who lived in sub-districts, non-urban/rural areas or recently migrated to the suburbs for economic reasons.

Conclusions

The systematic review of literatures reveals what can be highlighted as follows:

Evidence of health inequality among black South Africans, coloureds and Indians; analysis indicated 75% of black South Africans were more affected compared to coloureds and Indians.

Limited evidence of health inequality among whites; infants and older people

Although the methods, variables and samples differed, the results of all analysed studies were similar and reinforced the notion that 21 years after apartheid and the introduction of social grants, health inequality exists in South Africa.

Heterogeneity and variances in methods and measured variables in analysed studies reflect lack of consensus on acceptable measures/indices of health inequality.

Poor research on inequality in health related issues among ethnic minorities beyond provincial and urban/rural differentials.

No significant variation in health was noticed among whites regardless of their provincial / residential location. Besides, the only apparent explanation might be the association between the socio-economic status of whites at birth and the apartheid rule which had favoured whites over blacks and coloureds and still continues due to structural processes that tend to replicate the apartheid system.

In terms of health inequality being associated with income, years after apartheid rule, the legacy lives on and reflects in wage structure which appears to follow existing racial lines by maintaining a higher remuneration for whites who have higher chances of being employed with return to education estimated at 43%, compared to their black counterparts with similar qualifications who settle for lesser wages due to low employment

opportunities and approximate return to education as low as 7%. From the foregoing it is evident that using same demographics and given same opportunities/choices open to whites, inequality rates among Black South Africans reduced considerably. However, even though race, income and education score high as major influencers of health and health seeking behaviour, factors such as fertility rates, family background, religious/ cultural beliefs and large number of children/ households tended to influence health (inequalities) amongst blacks (African descents and coloureds) at all socio economic levels compared to whites and Indians/Asians.

The implication of the observed trend of general inequality on health in South Africa is that between races, inequality exists, is on the rise and explains poor health outcomes, low access to health services and health seeking behaviours among racial groups. And, within sub populations, health inequalities among black South African population is highest compared to whites and Indians/Asians and has increased significantly post-apartheid. Moreover, health inequality within residential locations has increased resulting in rural areas being disadvantaged in terms of availability of health resources/personnel due to health workers migrating to the urban areas and inequity in provision of health services as well as financing by the government being channelled towards urban areas where migrants/workers with higher earnings live and are able to pay /utilise services.

The concepts of 'literacy rate (illiteracy)' and 'income/earning differentials ' amongst others, have been used by scholars to structure the challenges that characterise inequalities in South Africa which are direct results of limited opportunities and racial/ethnic discriminations brought about by the apartheid legacy. Some of the effects of limited opportunities and racial discriminations include illiteracy, poverty, poor living conditions, racial residential segregation, mental health, maternal and infant mortalities, low health insurance coverage, poor access to health services and medicines, discrimination in health settings, disparities in quality of treatments and infectious diseases. Much worse is the fact that beyond racial differences, illiteracy and low income limit socio economic development of minority groups, increases chances of them living in poor conditions/unsafe vicinities where they are likely to pick up infectious diseases (faster than their more privileged counterparts who are born with better opportunities) and, in the case where they are able to access public health facilities, they are prone to experience disparities in treatment as well as other forms of discriminations in health settings.

The recent health inequality related protests by public health personnel and COSATU over the two-tier health system where tax rebates and other forms of government funding are channelled into the private health sector which services 8.5% of the population, majority of whom are whites compared with low funding of public health sector that caters for the health needs of over 43.8 million people who are mostly blacks . There are speculations that this trend in health inequalities represents a new form of economic apartheid where health affordability by the rich is being wielded as a weapon of oppression comparable to racial apartheid where whites oppressed blacks. Moreover, health inequalities in South

Africa are divided not just along racial lines but by gender and residential areas. Within the racially disadvantaged groups, black women are more likely to be affected by inequalities in health. In addition, those in sub districts within metropolitan cities tend to face similar challenges as those in rural areas who patronise public health facilities . In addition, among the white population, White south African males over the age of 45 are the worst hit by socio economic inequalities given the fact that they are considered part of the old dispensation (apartheid system) therefore as the previously advantaged people, they are made to go without a lot of social benefits and make up the bulk of unemployed. Besides, rising cost of living appears to be the most difficult challenge faced by this group of South Africans who make up the larger part of unemployed whites.

Although a number of scholarly literatures have sought to identify socio economic determinants of inequalities in health among various racial populations in South Africa (Agatugba 2011 & 2012; Wakeford 2001; Keswell 2010; Gradin 2013; Bradshw et al 2008), studies that apply sociological perspectives, intersectional approach and particularly, cross national comparisons to this occurrences among minority groups in developed and middle income countries is mainly limited.

For example, Goesling & Firebaugh (2004) studied trends in international health inequality by comparing average life expectancy among 169 countries from 1980 to 2000. In addition, Beckfield et al (2013) examined cross-national variation in inequalities in health among 48 countries and found significant disparity in health inequalities by gender, migration status, education and income. The relative lack of sociological cross national studies on not just structural conditions but ideological support that influence health inequalities among sub populations in mixed race societies is a particularly major omission. Given the fact that applying a sociological approach to cross national studies typically would reveal how government policies, dominant values and social/health structures contribute to and sustain inequalities in health. It is in this regard, that the effort of this paper can be viewed and the systematic review of the empirical studies of health inequality in South Africa can be considered as a useful contribution to the comparative examination of social inequalities in health across different countries in Europe and other parts of the world.

References

Evans T, Whitehead M, Diderichsen F. et al Introduction. In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. Challenging inequalities in health: from ethics to action. Oxford: Oxford University Press, 2013–11.11

The world health report (2000). Health systems: improving performance. Geneva, World Health Organization, 2000

World Health Organization (2006). Quality of care: A Process for Making Strategic

Choices in Health Systems. WHO, France

Howson C, Fineberg H, Bloom B (1998). The pursuit of global health: the relevance of engagement for developed countries. Lancet 1998351586–590.590

Foege W (1998). Global public health: targeting inequities. JAMA 19982791931–1932.1932 European Commission (2013). Health inequalities in the EU — Final report of consortium. Consortium lead: Sir Michael Marmot. Published by the European Commission Directorate-General for Health and Consumers. ISBN 978-92-79-30898-7,doi:10.2772/34426 http://ec.europa.eu/health/social_determinants/docs/healthinequalitiesineu_2013_en.pdf

BENATAR, S (2013). The challenges of health disparities in South Africa. South African Medical Journal, [S.l.], v. 103, n. 3, p. 154-155, jan. 2013. ISSN 2078-5135. Available at: <http://www.samj.org.za/index.php/samj/article/view/6622/4918>. Date accessed: 05 May. 2015. doi:10.7196/samj.6622.

Human Rights Watch. "Stop Making Excuses." Accountability for Maternal Health Care in South Africa. Johannesburg: Human Rights Watch. http://www.hrw.org/reports/2011/08/08/stop-making-excuses

Mackenbach J (2006). Health inequalities: Europe in profile. London: Department of Health.

Mackenbach J, Willem J, Anton K (2007). Economic implications of socio-economic inequalities in health in the European Union. Published by European Communities.

World health organization" Fact file :10 Facts On Health Inequities And Their Causes" http://www.who.int/features/factfiles/health_inequities/facts/en/index9.html

National Planning Commission (2011). National Development Plan Vision for 2030. Pretoria: National Planning Commission, http://www.npconline.co.za/medialib/downloads/home/NPC%20National%20Development%20Plan%20Vision%202030%20-lo-res.pdf.

Leibbrandt M, Woolard I, Finn A (2010).Trends in South African Income Distribution and Poverty since the Fall of Apartheid. OECD Social, Employment and Migration. Working Papers, No. 101. Paris: OECD Publishing, 2010. [http://dx.doi.org/10.1787/5kmms0t7p1ms-en]

World Bank (2012). South Africa Economic Update: Focus on Inequality of Opportunity. World Bank, Washington DC.

De Maio F, (2007) Income inequality measures. J Epidemiol Community Health. Oct;61(10):849-52. Review. PMID: 17873219 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652960/

Bailey, S (2012). Measures of "Race" and the analysis of racial inequality in Brazil. Social Sci. Res.http://dx.doi.org/10.1016/j.ssresearch.2012.06.006

Goldsmith H, Hamilton D, Darity W (2006). Shades of discrimination: skin tone and wages. American Economic Review 96 (2), 242–245.

Daynes S, Lee O (2008). Desire for Race. Cambridge University Press, Cambridge

Statistics South Africa (2012). http://www.statssa.gov.za/

Leibbrandt, M., Finn, A., & Woolard, I. (2012). Describing and decomposing post-apartheid income inequality in South Africa. Development Southern Africa, 29(1), 19-34

Hirschowitz, R., Orkin, M., de Castro, J., Hirschowitz, S., Segel, K., & Taunyane, L. (1995). A national household survey of health inequalities in South Africa. Overview report.

Frye I, Farred G, & Nojekwa L (2008). Inequality in South Africa. unknown publication), website: http://www. osisa. org/sites/default/files/sup_files/chapter_4_-_south_africa. pdf.

Nattrass N & Seekings J (2001). " Two Nations"? Race and Economic Inequality in South Africa Today. Daedalus, 45-70.

Gelb, S. (2003). Inequality in South Africa: Nature, causes and responses. Edge Institute.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: historical roots of current public health challenges. The Lancet, 374(9692), 817-834.

Woolard, I. (2002). An overview of poverty and inequality in South Africa. Unpublished briefing paper, HSRC, Pretoria (living standards and ethnic inequality)

Zeida R. Kon and Nuha Lackan. Ethnic Disparities in Access to Care in Post-Apartheid South Africa. American Journal of Public Health: December 2008, Vol. 98, No. 12, pp. 2272-2277.doi: 10.2105/AJPH.2007.127829

Özler, B. (2007). Not separate, not equal: poverty and inequality in post-apartheid South Africa. Economic development and cultural change, 55(3), 487-529

Demombynes, G., & Özler, B. (2005). Crime and local inequality in South Africa. Journal of Development Economics, 76(2), 265-292.

Adato, M., Carter, M. R., & May, J. (2006). Exploring poverty traps and social exclusion in South Africa using qualitative and quantitative data. The Journal of Development Studies, 42(2), 226-247.

Ataguba, J. E., Akazili, J., & McIntyre, D (2011). Socioeconomic-related health inequality in South Africa: evidence from General Household Surveys. Int J Equity Health, 10(1), 48.

Gakidou EE, Murray CJL, Frenk J:(2000) Defining and measuring health inequality: an approach based on the distribution of health expectancy. Bulletin of the World Health Organisation 2000, 78:42-54.

Ataguba J, McIntyre D(2009) Financing and benefit incidence in the South African health system: Preliminary results. Health Economics Unit, University of Cape Town Working Paper 09-1 2009.

Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D(2009) The health and health system of South Africa: historical roots of current public health challenges. The Lancet 2009, 374:817-834.

Ataguba JE, Akazili J (2010) Health care financing in South Africa: moving towards

universal coverage. Continuing Medical Education 2010, 28:74-78.

South African Governmnet (nd) Health http://www.gov.za/about-sa/health

Zere E, Moeti M, Kirigia J, Mwase T, Kataika E(2007) Equity in health and healthcare in Malawi: analysis of trends. BMC Public Health 2007, 7:78.

Human Rights Watch. (2011) "Stop Making Excuses." Accountability for Maternal Health Care in South Africa. Johannesburg: Human Rights Watch. http://www.hrw.org/reports/2011/08/08/stop-making-excuses

Labonte R, Schrecker T. (2011).The state of Global Health in a radically unequal World: patterns and prospects. In: Benatar S, Brock G, eds. Global Health and Global Health Ethics. Cambridge: Cambridge University Press, 2011:24-36

Bekker L (2009). An overview of HIV/AIDS in South Africa. Annual Review, Desmond Tutu HIV Foundation. Cape Town: Desmond Tutu HIV Foundation, 2009:6-7.

Ronelle B, Caryn B, Christelle G, Servaas B (2012) Have public health spending and access in South Africa become more equitable since the end of apartheid? Development Southern Africa Vol. 29, Iss. 5, 2012

Stuckler D, Basu S, & McKee M (2011). Health Care Capacity and Allocations among South Africa's Provinces: Infrastructure–Inequality Traps after the end of apartheid. American Journal of Public Health, 101(1), 165–172. http://doi.org/10.2105/AJPH.2009.184895

Harrison, D. (2009). An overview of health and health care in South Africa 1994–2010: Priorities, progress and prospects for new gains. Washington, DC: Henry J Kaiser Family Foundation.

Wagstaff, Adam. (2002). Poverty and health sector inequalities. Bulletin of the World Health Organization, 80(2), 97-105. Retrieved May 15, 2015, from http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0042-96862002000200004&lng=en&tlng=en. 10.1590/S0042-96862002000200004.

Ataguba, J. E.-O., & Alaba, O. (2012). Explaining health inequalities in South Africa: A political economy perspective. Development Southern Africa, 29(5), 756–764. http://doi.org/10.1080/0376835X.2012.730962

Commission on Social Determinants of Health. Achieving health equity: from root causes to fair outcomes. Interim statement. Geneva: Commission on Social Determinants of Health, World Health Organization; 2007

Castro-Leal F, Dayton J, Demery L, Mehra K(1999) Public social spending in Africa: Do the poor benefit? World Bank Research Observer 1999;14:49-72.

Statistics South Africa (2009) Living Conditions of Households in South Africa 2008/2009.

Statistics South Africa(2013) General Household Survey

Groenewald P, Bradshaw D, Daniels J, Matzopoulos R, Bourne D, Blease D. (2008) Cause of death and premature mortality in Cape Town 2001-2006. Cape Town: City of Cape Town, South African Medical Research Council, University of Cape Town

Gradín C (2013) Race, Poverty and Deprivation in South Africa J Afr Econ (2013) 22 (2): 187-238 first published online September 3, 2012 doi:10.1093/jae/ejs019

Leibbrandt M, Nicola B, Julia G and David L (2012) Education and Inequality: The South African Case. SADRU Working Paper Series Number 75

Keswell, M. (2010) 'Education and racial inequality in post-apartheid South Africa', in P. Attewell and K. S. Newman (eds), Growing Gaps: Educational Inequality around the World. Oxford: Oxford University Press

Erichsen, G. and J. Wakeford (2001) Racial Wage Discrimination in South Africa. Before and after the First Democratic Election, DPRU Working Paper, No 01/49, Development Policy Research Unit, University of Cape Town, South Africa.

Opinion Piece "Healthcare Inequality South Africa's New Apartheid – Vavi" October 30th 2014, SA breaking news. http://www.sabreakingnews.co.za/2014/10/30/healthcare-inequality-south-africas-new-apartheid-vavi/

Goesling, B, & Firebaugh G (2004). The trend in international health inequality. Population and Development Review, 30(1), 131-146.

Beckfield J, Olafsdottir S, & Elyas B (2013). Health Inequalities in Global Context American Behavioural Scientist August 2013 57: 1014-1039, first published on June 26, 2013 doi:10.1177/0002764213487343

The socio-economic well-being of internal migrants in Agbogbloshie, Ghana

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Abstract

The recent claims that migration can improve the well-being of migrants and thei dependants back home has mainly focused on international migration to destinations that are considered developed. Few studies have focused on internal migration and its effects on migrants' well-being. Besides, whether migrations to areas that are considered not developed can also contribute to improving the well-being of migrants and their dependants back home remains unaccounted for in the literature. This study employed a quantitative design involving descriptive statistics, independent t- test and binomial test to examine the effects of internal migration on the well-being of migrants in Agbogbloshie-the most populous slum in Accra. The study found that the determinants of well-being; income, education and employment have improved for migrants after migration. The results implied that migration had a net positive effect on migrants' well-being. However, this benefit comes at a cost as migrant workers are engaged in works that post a lot of risk such as carrying very heavy loads, exposed to toxic substances and living in very poor accommodation. The paper recommends that efforts be made by governments to bridge the development gap between the north and south of the country so as to limit the rate of migration.
Keywords: *Migration, Development, Well-being, Poverty, Income distribution, Ghana*

Résumé

Les récentes allégations que la migration peut améliorer le bien-être des migrants et thei charge retour à la maison a principalement porté sur la migration internationale vers des destinations qui sont considérés comme développés. Peu d'études ont porté sur la migration interne et de ses effets sur le bien-être des migrants. En outre, si les migrations vers les zones qui ne sont pas considérés développé peuvent également contribuer à améliorer le bien-être des migrants et de leurs familles à la maison reste portées disparues dans la littérature. Cette étude a utilisé une conception quantitative impliquant statistiques descriptives, test t indépendant et test binomial pour examiner les effets de la migration interne sur le bien-être des migrants dans le bidonville d'Agbogbloshie-le plus peuplé à Accra. L'étude a révélé que les facteurs déterminants du bien-être; le revenu, l'éducation et l'emploi se sont améliorées pour les migrants après la migration. Les résultats implicite que la migration a eu un effet net positif sur le bien-être des migrants. Toutefois, cet avantage a un coût que les travailleurs migrants sont engagés dans des œuvres qui affichent beaucoup de risques comme porter des charges très lourdes, exposés à des substances toxiques et de vivre dans un logement très pauvre. Le document recommande que des efforts soient déployés par les gouvernements pour combler l'écart de développement entre le nord et le sud du pays afin de limiter le taux de migration.
Mots-clés: *migration, le développement, le bien-être, de pauvreté, répartition des revenus, Ghana*

Introduction

There has been increased interest in the relationship between migration and development among governments, Civil Society Organizations (CSOs) and development agencies in recent years. This interest is informed by the claim by many scholars that remittances from migrants abroad can be an effective instrument for income redistribution, improvement in well-being and economic growth than large bureaucratic development programs or development aid (Jones, 1998; Kapur, 2003; Ratha, 2003; de Haas, 2010). Whereas a plethora of literature abounds on the impact of international migration on development, few studies have focused on how internal migration affects the well-being of migrants and their dependants (Black and Sward, 2009), yet there is evidence to show that internal migration is on the increase in many countries due to inequitable distribution of facilities and development opportunities (Ghana Statistical Service, 2005; Anarfi and Kwankye, 2005).

Like many developing countries, Ghana has the problem of uneven development and inequitable distribution of basic social amenities between rural and urban areas. Facilities for higher education, quality healthcare, major sports and entertainment facilities, telecommunication, and the modern economy are all concentrated in the big cities such as Accra, Kumasi and Takoradi (Twumasi-Ankrah, 1995; Anarfi et al, 2003). This dualism and disparities in development were inherited from the colonial administration. For example the British colonial government perceived the southern forest region of the country to have the strongest potential for development and consequently promoted the northern savannah region to be the source of labour for the industrial and the productive agricultural sector located in the Southern regions of the country (see Caldwell, 1969; Nabila, 1985; Anarfi et al, 2003; Awumbila and Ardayfio-Schandorf, 2008).

After more than five decades of political independence and the implementation of numerous rural development programmes by the various governments, the problem of uneven development still persists especially between the Southern part of the country

and the three Northern Regions. Undoubtedly, this situation has resulted in seasonal and sometimes permanent migration of young people from the three Northern Regions to the southern sector in search of jobs (see Twumasi-Ankrah, 1995; Awumbila and Ardayfio-Schandorf, 2008).Analyses of Ghana's population censuses since 1960 confirm the above assertion. The census results have revealed that the three Northern Regions have largely been net out-migration areas. In the 1960 population census, the Northern, Upper East and Upper West regions had a net out migration of –157,055. In 1970, the three regions recorded a net out-migration of – 33,719. In 1984 however, while there was a net gain of 10,716 for the Northern region, the Upper East and Upper West regions suffered a net loss of 20,762 and 3,083 persons respectively. By 2000, all the three regions were affected by large volumes of net losses of population, which stood at 139,216 for the Northern Region, 201,532 for the Upper East Region and 191,653 for the Upper West Region (Ghana Statistical Service, 2005; Anarfi and Kwankye, 2005).

The rationale for migrating and the decision making process of these migrants have been thoroughly explored over the years (see Opare, 2003; Tanle, 2003; Anarfi, 2003, Awumbila, 2007; Yeboah, 2008; Kwankye et al, 2009). All these studies have found that most young migrants were the ones who took the decision to migrate. Evidence also points to "*push- factors*" that is moving away from the vagaries of rural living and then "*pull factors*" such as western industry, commerce, Information and Communication Technology (ICT) and bright lights of the urban areasas the causes of most rural-urban migration (Twumasi-Ankrah, 1995; Opare, 2003; Tanle, 2003; Anarfi et al, 2003; Awumbila, 2007; Yeboah, 2008 and Kwankye et al, 2007). The building of better roads, improvement in transportation services and the rapid growth in the telecommunication sector have only served to facilitate migration from the rural areas to urban centres.

A review of the many works done on the North-South migration in Ghana reveals that the effects of such movements on the well-being of these migrants and their dependants is yet to be critically examined, especially in the context of the growing interest in using well-being measures to evaluate societal progress. Although the concept of well-being is widely used, there is no commonly agreed definition of just what it is and how it should be measured. Moreover, the terms well-being, quality of life, happiness and life satisfaction are often used interchangeably (see Diener et al, 2003; Diener, 2009; Nowok et al, 2011).

According to the New Economics Foundation (2008), well-being is a dynamic state, in which the individual is able to develop his or her potential, work productively and creatively, build strong and positive relationships with others, and contribute to his or her community. It is enhanced when an individual is able to fulfill his or her personal and social goals and achieve a sense of purpose in society. Naess (1999) sees well-being as the individual's experience, or perception, of how well he or she lives. This is taken as the criterion of quality of life or well-being.

In this paper well-being is used to mean the individual assessment of how well he or she is within the context of incomes, health status, and educational aspirations.

Migration and the Development mantra

As far back as a century ago, Ravenstein, the father of modern migration studies, observed that migration increases as industries and commerce develop and transport improves (see Grigg, 1977). In other words, migration has positive correlation to development. Ravenstein further asserted that migration was mostly from agricultural areas to the centres of industry and commerce and that the major cause of migration was the economic factor. Many studies on migration therefore focused on exploring the economic causes of migration; the extent to which migration affects the individual migrant's well-being does not appear to have received adequate scholarly attention.

In the 1950s, the dualistic literature on economic development viewed migration of labor out of the rural sector into industrial production as the key to modernization and income growth. The Kuznets curve portrayed an inequality between those fortunate enough to relocate in town versus those left in poverty in the rural areas. It was believed that as urbanization proceeds, average incomes rise and the dispersion of income later narrows because fewer are left in agrarian destitution (Lucas, 2007). These early frameworks presumed the existence of a surplus pool of labor in the villages and the removal of labor to town consequently left agricultural production unaffected. Within these dualistic models, the decision to migrate or not was at the discretion of the individual potential migrant. Moreover, migration was treated as permanent moves; a life changing, discrete choice, usually taken early in life in order to reap the benefits over a longer time horizon (Lucas, 2007).

Perhaps the most popular migration theory is the Lee's Push-pull model (1966). Lee explained migration as a consequence of factors pertaining to places of origin and destinations. For Lee, migration is a decision that an individual or family makes which could be rational or irrational and for every act of migration the following elements are present: origin, intervening obstacles and destination. The decision to migrate is influenced by four factors namely: a) factors pertaining to the area of origin b) factors associated with the area of destination c) intervening obstacles and d) personal factors.

Push-pull model does not appear to give adequate recognition to the diversity and internal stratification of societies. Generally, while general contextual factors that are defined as either push or pull factors are likely to work out in a differentiated way on the individual level, and might subsequently encourage some people to leave and others to stay. Another fundamental oversight of Lee's model is that push and pull factors are generally mirrored in each other. For example, the argument that migrants are lured to big cities or to foreign countries because of the high wage '*pull*', is implicitly or explicitly made in relation to an apparent low wage '*push*' at the sending end.

Stark (1991) was the leading proponent of the New Economics of Labour Migration (NELM) model. There are two main strands of the NELM. The first is to recognize

that migration decisions are not individual decisions but joint decisions taken within the ambit of the household, and for different members of the household, extended family and community (see also King, 2013; Massey et al., 1998). The second aspect of the NELM theory is that the decision to migrate is not only about wages and income maximization but it is also about income diversification and risk aversion.

Taking these two perspectives together, it can be seen that families and households are in the position to control risks to their economic well-being by diversifying their income-earning and livelihood resources into a portfolio of different activities, spreading their labour resources over space and time. Different family members can thus be allocated to different tasks: one or more on the farm, another perhaps engaged in internal migration and others in international migration. Remittances from these migrants can be used to cover the basic costs of everyday life such as food, clothing, or to invest in some new projects in the event that farming fails.

The arguments raised by these migration theories suggest that the destinations for migrants are well-off or successful areas or developed urban settings and therefore *pulling* people to migrate. For migration to be economically productive, one must migrate to geographic locations that are well-off. What these theories do not adequately address is whether areas that are considered as slums or undeveloped in urban areas can offer any hope to migrants. According to UN-HABITAT (2006b), a slum is an urban area that lack one or more of the following facilities: durable housing of a permanent nature and sufficient living space which means not more than three people sharing the same room. The residents in a slum do not have access to safe water in sufficient amounts at an affordable price and there is inadequate sanitation in the form of private or public toilets shared by a reasonable number of people. These settlements are also known for their atmosphere of fear and violence (see Bloom et al, 2008).

In spite of all these, slums attract many migrants. What is however unclear is whether slums offer any opportunities for the improvement in the well-being of migrants. Again, current literature does not provide answers as to whether the effects of slums on migrants can offer any lessons to migration and development policy.

Study context and Methodology

The study was conducted in two areas: Agbogbloshie located in the heart of Accra, the capital city of Ghana and Yendi in the Northern Region. Agbogbloshie is the most populous slum in Accra with inhabitants from all the three Northern regions of Ghana (Housing the Masses, 2009; Lartey and Blatyne, 2011; Ankrah, 2011). The choice of Agbogbloshie was largely informed by the fact that the settlement is home to most of the migrants from Northern Ghana to Accra. The area is about 31.3 hectares and less than a kilometer from the Central Business District (CBD) of Accra as seen in Figure 1.

Figure 1: Map of Accra Metropolitan Area showing Agbogbloshie

Source: GIS, 2014.

The Yendi Municipality was chosen because the available evidence shows that over 65 percent of the migrants in Agbogbloshie are from the Dagomba and Konkomba ethnic groups mostly based in the Yendi Municipality (Housing the Masses, 2009).

The paper employed quantitative research design to establish whether there is a relationship between migration and well-being. The logit regression model was used in determining the relationship between migration and socio-economic well-being of migrants. One of the advantages of this approach is that it enables us to know the actual relationships between two or more variables being studied. With this we are able to describe fine differences between people in terms of the characteristics being studied as well as providing a consistent yardstick for arriving at such distinctions (Alan, 2008; Aliaga and Gunderson, 2000).The descriptive method was used by employing percentages and mean values to present the results of the analyses on the variables of interest. This provided a comprehensive understanding of the results in the very descriptive form.

The sample size was selected from the population of Agbogbloshie and Yendi. Within the population of Agbogbloshie, a sample frame consisting of migrants from the three northern regions was determined. The estimated population of the inhabitants from the three Regions in Agbogbloshie was 56,880 representing 77 percent (Housing the Masses, 2009). Using the 56,880 persons as the sample frame and a 95 percent confidence level, the sample size for Agbogbloshie was 398. Using the same method a sample size of 301 was obtained for Yendi with similar age characteristics as those in Agbogbloshie.

The data was analyzed using the Statistical Package for Social Science version 16.0 and Stata 12.0.The quantitative data analyses employed descriptive statistics using percentages, tables and charts. The binomial test was used to determine if the educational levels of the respondents had improved after migration by comparing the educational levels of the migrants and non- migrants in Yendi. The ordered logit regression model was used to test the effect of migration on status of migrant's socio-economic well-being. An independent t – test was used to compare the means of incomes of migrants and non-migrants in order to test the hypothesis that income of migrants is greater than that of non-migrants;

H0: Mean (diff) = 0 H1: Mean (diff) > 0

The null hypothesis H_0 states that there is no statistical difference between the mean income of migrants and the mean income of non-migrants. That is the study postulates that the incomes of migrants did not improve after migrating. The alternative hypothesis H_1 states that there is a statistical difference between the mean income of migrants and the mean income of non-migrants. Thus the alternative hypothesis holds that income of migrants after migration are greater relative to non-migrants, which means that migration would have improved the well-being of migrants in terms of income compared to non-migrants. The t-test was used because the two means to be compared (income of migrants and income of non-migrants) have independent samples from different populations (migrants and non-migrants). The *t*-test follows the normal distribution of zero mean difference and a constant variance.

Findings and Discussion

Reasons for migrating to Agbogbloshie

The study found that majority (84percent) of the migrants migrated to seek employment. About 80 percent indicated that they were employed. Only 20 percent of the respondents were unemployed. The results further showed that 50 percentof the migrants migrated in order to have access to quality education. Thirty-nine percent had done so to escape outmoded cultural practices such as female genital mutilation and forced mariages.Only one percent of the migrants migrated because they were transferred to the South by their employers. For about 50 percent of them, other reasons for migrating were to look for resources to expand or start up business.The three common jobs that the migrants were employed to do were security guards in private companies, head-porterage popularly known in Ghana as *kayayei*, dealing in scrap metals, cleaning and petty trading. All the head porters asserted that their current jobs were risky compared to their jobs back home.The remaining 32 respondents (8 percent) indicated that there was no much risk at their places of work. They indicated that the carrying of heavy loads was most risky for them. Other risks they mentioned were being knocked down by vehicles, frequent fire gutting their belongings and the exposure to miscreants such as thieves and rapists. Also, most of the migrants complained about poor accommodation and poor sanitation as there were no gutters and other drainage systems in the area. Most of the migrants were of the opinion that their previous accommodation in Yendi was far better than what they had in Agbogbloshie.

These findings are consistent with the claims by most theories on migration. Although several factors determine why people migrate, the determinants of migration are usually categorized into '*push*' and '*pull*' factors (see Lee, 1966; Mabogunje 1970, Lewis, 1982; Todaro, 1997). Outmoded cultural practices, lack of jobs and education facilities in Yendi can be termed as the *push* factors. These are factors within a particular geographical location that turn to serve as a repelling force to drive people away to leave that location. The opposite is true with factors in certain geographic regions that tend to attract migrants; people may be pushed off by poverty in rural areas to relocate to towns permanently or temporally. On the other hand, pull factors in cities such as Accra and Kumasi are the better employment opportunities or better facilities that encourage people to move to these urban centres.

These findings further support the view that migration from the three Northern Regions to the Southern part is a response to imbalances in development (Awumbila, 2007; Yeboah, 2008). As the survey results showed over 80 percent of the sampled migrants in Agbogbloshie moved in response to seek job opportunities in Accra. This

goes to validate Harris and Todaro (1970)'s model of migration which sees migration as a response to wages differentials between two geographical areas. The findings are also consistent with Ravenstein law of migration that economic factors are the major causes of migration (see Grigg, 1977). What this points to is that development policy needs to channel investment to deprived regions in the country.

Effects of education on migration

The binomial test indicates that statistically there was no significant difference in the proportion of the migrants that had formal education and the proportion of the non-migrants without formal education. The results are presented in table 1.

Table 1: The binomial test of educational level proportions

Level of Education	Proportion with Level of Education		P-Values	
	Migrants (S)	Non-migrants (N)	(H0: S > N)	(H1: S < N)
None	0.2836	0.3154	0.905	0.116
Primary	0.1287	0.0738	0.000	0.999
JHS	0.2368	0.2315	0.428	0.621
SHS	0.3099	0.2383	0.001	0.998
Tertiary	0.0409	0.4564	1.000	0.000

Source: Authors' field survey, May, 2014.

As shown in table 1, 28 percent of the migrants had no formal education while 31 percent of the non-migrants had no formal education. A similar result was found for the proportion of the migrants who had Junior High School level education. There was no statistical evidence to support the assertion that more of the migrants had JHS education compared to the non-migrants.

In the case of Senior High School, 31 percent of the migrants had Senior High School level education compared to about 24 percent of the non-migrants. The binomial test result showed that a greater proportion of the migrants had SHS level education compared to the non-migrants. The situation is similar in the case of Primary education. More of the migrants had primary level education compared to the non-migrants. The situation was the reverse in the case of tertiary level education. Most of the non-migrants had tertiary level education compared to the migrants. Thus the alternative hypothesis that more of the migrants had higher education compared to the non-migrants was rejected. Overall, the results showed that a larger proportion of the migrants had primary

and secondary level education compared to the non-migrants but a greater proportion of the non-migrants had higher-level education compared to the migrants.

The results suggest that migrating to Agbogbloshie is selective. People with tertiary level education in the three Northern Regions are not likely to migrate to Agbogbloshie. Persons with tertiary education may migrate to other parts in Southern Ghana that may offer jobs for their qualifications and not Agbogbloshie which is considered a slum. It has been argued that education is a major factor that induces rural-urban migration. For instance, Oberai (1978) found a strong correlation between the propensity to migrate and one's level of education and this has been observed in many developing countries. On the contrary, Adepoju (1995) found an increase in migration of illiterate persons from the rural areas to urban informal sectors.

Effects of migration on education

Our findings in Agbogbloshie revealed that 77 percent of the respondents had improvement in access to education, 16 percent of the respondents indicated that their access to education had rather worsened whilst the remaining 7 percent claimed their access to education remained the same implying that migrating to Agbogbloshie had no impact on their education. For those who claimed migration had improved their access to education, their responses revealed that they schooled during the day and worked in the night. This was peculiar to those working as security guards and cleaners. In any case migration had a positive effect on migrants' education since it opened the economic doors to save and continue schooling in the South.

There is evidence that remittances have played important role in contributing to the education of migrants' children in the Philippines, El Salvador, Guatemala, Nepaland Pakistan (see Yang, 2004; Edwards and Ureta, 2003; Adams, 2006; Thieme and Wyss, 2005; Mansuri, 2007).In spite of the seemingly positive correlation between education and migration, there are claims that migration can also create disincentives for education. For example, Mexican household surveys indicate that international migration has had a negative effect on the level of education of the children of international migrants (McKenzie and Rapoport 2007). It has been argued that Mexican migrants' educational qualifications have little impact on the type of jobs most migrants can acquire in the United States of America, and this may influence their ideas about whether educational investments are worthwhile, particularly if their children are also planning to migrate.

Effects of migration on the income of migrants

The study found that majority (77 percent) of the migrants claimed that their income levels had improved after migrating to Agbogbloshie, 20 percent of the migrants

indicated that their income level had remained the same with only 3 percent having a reduction in their incomes. The descriptive statistics showed that on the average a migrant made about GH¢335 (US$ 113) a month while a non-migrant from the Yendi Municipality on the average made about GH¢195 (US$66) a month (see table 2). The independent t-test results revealed that the average income for the migrants was statistically different from the average incomes of the non-migrants with a difference of about GH¢140 (US$48). Thus the migrants made almost twice the amount made by the non-migrants in a month. This finding agrees with the main reason for migrating which was to get better paying jobs and improve living conditions. That is the income difference was instrumental in the decision of the migrants to migrate.

Table 2: The Independent t-test results for income in GH¢

Income	Mean	Std. Error	Std. Deviation
Non-migrant	195.143	11.6242	181.577
Migrant	335.049	11.9792	187.121
Null Hypothesis	Mean (diff) = 0	Mean (diff) = 0	Mean (diff) = 0
Alternative Hypo.	Mean (diff) < 0	Mean (diff) ≠ 0	Mean (diff) > 0
P-value	0.0000	0.0000	1.0000

Note: Mean (diff) = (income of non-migrants – income of migrants)

Source: Authors' field survey, May, 2014.

Migration and remittances

The study found that 65 percent of the working migrants sent remittances to their families back home (see table 3). The remittances ranged between GH¢100 (US$ 34) and GH¢399 (US$102 - US$136). Majority (48 percent) of these migrants sent their remittances *as and when the need arises*. About 35 percent sent theirs every month, 5 percent sent their remittances weekly and 10 percent did it once year.

Table 3: How often remittances are sent

How often Remittances were sent	Frequency	Percentage (%)
As and when the need arise	122	48.40
Monthly	90	35.62
Weekly	13	5.02
Yearly	28	10.96
Total	254	100

Source: Authors' field survey, May, 2014.

Our findings with regards to the motives of remittances to areas of origin are based on these three models and the findings validate these theories. The study found that majority of the migrants remit on the basis of pure self-interest (65 percent) while the remain 35 percent sent money to take care of relatives and to pay debts which falls in the category of pure altruism and tempered altruism. For 64 percent of the respondents, they had been able to achieve their aim of migrating to Agbogbloshie. The indicated that they have been able to purchase personal items (43 percent), repaid debts (24 percent), saved some money (43 percent), finance children's education (64 percent) and sent money back home to relatives (87 percent). For most of these migrants, migration had given them the exposure to other means of livelihood apart from the traditional occupation of peasant farming which most of them were previously engaged in.

Many studies on the determinants of remittances have shown that three main reasons account for remittances: pure altruism or selflessness, pure self-interest and tempered altruism or enlightened self-interest. Although it can be difficult to establish a difference between altruism and pure self-interest, altruism is the principle or practice of concern for others. The theory of altruism posits that the migrant derives a positive utility from the well-being of the family left behind (see Becker 1974; Lucas and Stark, 1985; Stark, 1991; 1995). Pure self-interest generates three motives for migrants to send remittances home. The first arises from the belief that if the migrant takes care of the family, a larger portion of the family wealth would be bequeathed to her in later years. The second motive is to build up assets at home such as land, house and livestock. The third motive may arise from intent to return home at a later stage which would require investment in fixed assets, in a business or in community projects if the migrant has political aspirations. Tempered altruism or enlightened self-interest is a contractual arrangement between the migrant and the household left behind for example co-insurance, exchange-motives, loan repayment. Such contractual arrangements are based on investment and risk. In the case of investment the family bears the cost of educating the migrant worker who is expected to repay the investment in the form of remittances (see Lucas and Stark, 1985; Hagen-Zanker and Siegel, 2007).

Conclusion

This paper sets out to assess the effects of migration on the socio-economic well-being of migrants in Agbogbloshie. The paper has shown that slums can offer some hope to the poor migrant. We have shown evidence that migration has had enormous impact on migrants' incomes thereby improving their well-being. The descriptive statistics showed that on average a migrant made about 335 Ghana cedis a month while a non-migrant on average made about 195 Ghana cedis a month. The statistical test indicated that the average income for the migrants was statistically different from the average income of the non-migrants. In other words, on average the monthly income of a migrant

outweighs the monthly income of the non-migrant by about 140 Ghana cedis. Thus, the migrants on an average made almost twice the amount made by the non-migrants in a month. Even though the cost of living in Accra is higher compared to that of the three Northern Regions, the fact that migrants were able to remit shows that they were better off in terms of incomes than their counterparts in Yendi. Based on all these, it can be concluded that migration from the three northern regions to Agbogbloshie has welfare gains not only in income but also in education and employment which are key ingredients of well-being measures.

The major cause of migration from the three Northern regions to the southern part of the country is economic. This gives insight in terms of what development policy must focus on in the investment decisions that are made. The concentration of livelihood opportunities in few urban centres without corresponding investments in deprived regions of the country needs policy attention.

Policy Recommendations

Commitment to rural development initiatives

The government needs to intensity the implementation of pro-poor policies and development initiatives that seek to achieve equitable distribution of investments in the country. The focus must be on the provision of basic services in rural areas. These include electricity, potable water, well-functioning rural clinics and recreation facilities. Although the availability of these facilities might not completely halt rural-urban migration, they can contribute to reducing these flows. The idea is not to discourage internal migration but to improve upon the living conditions of the entire country.

Promote agricultural development

There is the need for integrated rural development strategy to increase agricultural production and to make the agricultural sector more productive and attractive. This can be done by increasing rural labour productivity through improving farm technology, increasing access to farm inputs such as fertilizers, high yielding variety of seeds, insecticides and adequate agricultural extension services. The Ministry of Food and Agriculture, the Ministry of Local Government and Rural Development and District Assemblies must collaborate to improve access to financial credit and market facilities in rural areas. The government should task research institutions such as the Grains Development Board and Savannah Agricultural Research Institute to collaborate and intensify the development of irrigative technologies to support all-year-round agriculture

Improving security and general infrastructure in Agbogbloshie

The government must improve upon the security situation through equipping the police to intensify their visibility in the area. The drainage system, water and sanitation and the drainage system need to be improved to reduce the risk of an outbreak of epidemic such as cholera and other sanitation and water related health risks.

References

Adams Richard. 2006. Remittances and Poverty in Ghana. *World Bank Policy Research Working Paper*, No. 3838. Washington DC: World Bank.

Adepoju, Aderanti . 1995. "Emigration dynamics in Sub-Saharan *Africa* International Migration." (Special Issue on Emigration Dynamics in Developing Countries) *International Social Science Journal* 33: 31-44

Alan, Bryman. 2008. "Of methods and methodology: Qualitative Research in Organizations and Management." *An International Journal* 32: 159-168

Aliaga, Martha and Gunderson, Brenda. 2000. Interactive Statistics. Saddle River.

Anarfi, John. 2003. *Migration from and to Ghana, A background paper. Migration DRC Working Paper*: No.C4. Sussex: Development Research Centre on Migration, Globalization, and Poverty. Retrieved on 4th March, 2014, from: www.sussex.ac.uk/migration

Anarfi, John., Kwankye, Stephen., Ababio, Ofosu-Mensah and Tiemoko, Richmond. 2003. *Migration from and to Ghana: A Background paper. Migration DRC Working Paper*, No. C4. 138. University of Sussex: Development Research Centre on Migration, Globalization and Poverty

Anarfi, John and Kwankye, Stephen. 2005. *The Costs and Benefits of Children's Independent Migration from Northern to Southern Ghana'*. Paper presented at the International Conference on Childhoods: Children and Youth in Emerging and Transforming Societies. Oslo, Norway, 29 June – July 3, 2005

Ankrah Mary. 2011. Empowerment through Enumeration. In L. Bain, ed. *Faces of Old Fadama Western Publications*. Retrieved on 10-12-2013 from*www.sdinet.org/media/upload/countries/.../Faces_of_Old_Fadama.pdf*

Awumbila, Mariama and Ardayfio-Schandorf, Elizabeth. 2008. "Gendered Poverty, Migration and Livelihood Strategies of Female Porters in Accra, Ghana." *Norwegian Journal of Geography* 62(3): 171-179

Awumbila, Mariama. 2007. Internal migration, vulnerability and female porters in Accra, Ghana. Paper presented at the Population Association of America 2007 Annual Meeting. Accessed from January 2, 2008, from http://paa2007.princeton.edu/download.aspx?submissionId=70865

Becker, Gary. 1974. "A Theory of Social Interactions." *Journal of Political Economy* 82: 1063-1093

Black, Richard. and Sward, Jon. 2009. Poverty Reduction Strategies and Human Development. Human Research Paper for UNDP. Retrieved on 20-10-2013 from: hdr.undp.org/.../migration-poverty

Bloom, David, Canning, David and Fink, Gunther . 2008. "Urbanization and the wealth of Nations." *Science* 319: 772-775

Caldwell, John Charles. 1969. African Rural-Urban Migration: The Movement to Ghana's Towns, Canberra, Australia: Australian National University Press.

De Haas, Hein. 2010. "Migration and development: a theoretical perspective." *International Migration Review* 44(1): 22764

Diener, Edward,Christie Napa, Scollon. & Richard, Lucas .2003. "The evolving concept of subjective well-being: the multifaceted nature of happiness." *Advances in Cell Aging and Gerontology* 15: 187-219

Diener, Edward. 2009. Subjective well-being. In The Science of Well-Being: The Collected Works of Ed. E. Diener (Springer, The Netherlands) 11-58

Edwards, Alejandra. & Manuelita, Ureta. 2003. "International migration, remittances, and schooling: Evidence from El Salvador." *Journal of Development Economics* 72(2): 429–461

Ghana Statistical Service (GSS). 2005. 2000 Population and Housing Census, Population Data Analysis Reports, vol. 1: Socio-economic and Demographic Accra: Ghana Statistical Service. Accessed on 20-10-2013 from: *www.statsghana.gov.gh/*

Geographic Information Systems (GIS). 2014. Maps of Accra Metropolis. Department of Planning, GIS Laboratory, KNUST

Grigg, David .1977. "E. G. Ravenstein and the 'laws of migration." J*ournal of Historical Geography* 3(1):41–54

Hagen-Zanker, Jessica & Melissa, Siegal. 2007. The Determinants of Remittances: A Review of Literature. Working Paper MGSoG/2007/WPOO3, Maastricht University, MaastrichtGraduate School of Governance

Harris,John. and Todaro, Michael. 1970. "Migration, Unemployment and Development: A Two Sector analysis." *American Economic Review* 60(1): 126-142

Housing the Masses. 2010. People's Dialogue on Human Settlements: Final Report on Community-Led Enumeration of Old Fadama Community, Accra-Ghana, Accra, Ghana. Accessed on 20/11/2013 from: *www.sdinet.org/.../2009.May3.2010.Old_Fadama_Enumeration-1_1.pdf*

Jones, Richard. 1998. "Introduction: The renewed role of remittances in the New World Order." *Journal of* Economic *Geography*, 74(1): 1–7

Kapur, Devesh. 2003. Remittances: the new development mantra. Paper prepared for the G-24 Technical Group Meeting, 15–16 September (Geneva: Palais des Nations). Retrieved on 10-02-2013 from*: www.citieslocalgovernments.org/.../gdsmdpbg2420045_en_en.pdf*

King, Russell. 2013. Theories and Typologies of Migration: An Overview and a Primer. Willy Brandt Series of Working Papers in International Migration and Ethnic Relations. Malmo Institute for Studies of Migration, Diversity and Welfare (MIM). University of Malmo. Retrieved on 10-02-2013 from: www.mah.se/upload/forskningscentrum/mim/wb/wb%203.12.pdf

Kwankye, Stephen; Anarfi, John; Tagoe, Cynthia and Castaldo, Adrian. 2009. Independent North-South Child Migration in Ghana: The Decision Making Process". Sussex Centre for Migration Research Working Paper T-29. February.

Kwankye, Stephen., Anarfi, John. , Addoquaye, Tagoe Cynthia & Castaldo, Adriana. 2007. Coping Strategies of Independent Child Migrants from Northern Ghana to Southern Cities Development Research Centre on Migration, Globalisation and Poverty Working. Paper Series, University of Sussex. Retrieved on 10-02-2013, from: *www.migrationdrc.org/publications/working_papers/WP-T23.pdf*

Lartey, Ernest and Blatyne, Darko. 2011. Heath and Sanitation in Old Fadama, not a Government Priority. In Faces of Old Fadama (eds.) Western Publications. Retrieved on 10-12-2013, from: *www.sdinet.org/media/upload/countries/.../Faces_of_Old_Fadama.pdf*

Lee, Everett. 1966. "A Theory of Migration." *Demography* 3(1):47-57.

Lewis, Gareth. 1982. *Human migration: A geographical perspective*, New York, St. Martin's Press

Lucas, Robert & Oded. Stark. 1985. "Motivations to remit: Evidence from Botswana." *Journal of Political Economy* 93(5): 901-18

Lucas, Robert. 2007. "Migration and rural development." *Journal of Agricultural and Development Economics* 4 (1), 99-122

Mabogunje, Akin. 1970. "*S*ystem approach to a theory of rural-urban migration." *Geographical Analysis* 2(1):1-18

Mansuri, Ghazala. 2007. Does work migration spur investment in origin communities? Entrepreneurship, schooling and child health in rural Pakistan', International Migration, Economic Development & Policy, Özden, C. and M. Schiff, eds. Washington DC: World Bank.

Massey, Douglas; Arango, Joaquin, Hugo, Graeme; Kouaouci, Ali; Adela Pellegrino & Edward Taylor. 1998. Worlds in motion: Understanding international migration at the end of the millennium. Oxford: Clarendon Press.

McKenzie, David & Rapoport, Hillel. 2007. "Network effects and the dynamics of migration and inequality: theory and evidence from Mexico." *Journal of Development Economics* 84 (1):1–24.

Nabila, John. 1985. Internal Migration and regional development in Ghana, in RIPS (ed). Internal migration development in Africa, Legon, Accra. 205-223.

Naess, Siri. 1999. "Subjective Approach to Quality of Life." *Feminist Economics* 5(2):115-118

New Economics Foundation. 2008. Measuring Well-being in Policy. Accessed on 10-10 -2013 from: http://www.neweconomics.org/publications

Nowok, Beata; Van ham, Maarten; Findlay, Allan & Gayle, Vernon. 2011. Does Migration Make You Happy? A Longitudinal Study of Internal Migration and Subjective Well-Being. IZA DP No. 6140, Discussion Paper No. 6140. Accessed on10-10-2013from http://ftp.iza.org/dp6140.pdf

Oberai, Amarjit. 1978. Determinants of Rural-Urban Migration and its Implications for Rural Areas with Special Reference to ILO Research. Economic and Demographic: Issues for the Proceedings of the Conference, Volume2Helsink: International Union for Scientific Study of Population. Accessed on10-10-2013 from:*www.popline.org/node/443363*

Opare, James Adu. 2003. "Kayayei: The women head porters of southern Ghana. *Journal of social development in Africa* 18(2):33-48

Ratha, Dilip. 2003. Workers' remittances: an important and stable source of external development finance. In World Bank, Global Development Finance 2003, 157- 175 (Washington: World Bank).Accessed on 10-10-2013 from*www.siteresources.worldbank.org/*

Stark, Oded. 1991. The migration of labor, Oxford and Cambridge, MA: Basil Blackwell.

Stark, Oded. 1995. *Altruism and Beyond*. Oxford and Cambridge: Basil Blackwell.

Tanle, Augustine. 2003. Rural-urban migration of females from the Wa District to Kumasi and Accra: A case Study of the Kayayei Phenomenon. Master Thesis Submitted to the Department of Geography and Tourism, University of Cape Coast. Accessed on 10-12-2013 from:www.*ir.ucc.edu.gh/dspace/bitstream*

Thieme, Susan. & Wyss, Simone. 2005. "Migration patterns and remittance transfer in Nepal: a case study of Sainik Basti in Western Nepal." *International Migration* 43(5): 59-98.

Todaro, Michael. 1997. Economic Development. Reading, Mass: Addison-Wesley.

Twumasi-Ankrah, Kwaku. 1995. "Rural-urban migration and socioeconomic development in Ghana: some discussions." *Journal of Social Development in Africa* 10(2):13-22

UN-HABITAT. 2006b. State of the World's Cities 2006/2007: The Millennium Development Goals and Urban Sustainability, Earth scan, London.

Yang, Dean. 2004. International Migration, Human Capital, and Entrepreneurship: Evidence

from Philippine Migrants' Exchange Rate Shocks. Ann Arbor: University of Michigan Press.

Yeboah, Muriel Adjubi. 2008. Gender and Livelihoods: Mapping the Economic Strategies of Porters in Accra, Ghana. PhD Dissertation, West Virginia University, Morgantown. Retrieved on 10-12-2013 from https://eidr.wvu.edu/etd/documentdata.eTD?documentid=5755

Successful ageing amongst elderly women living independently in central areas Of Pretoria, South Africa

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Abstract

This qualitative study explores successful ageing among a group of old women who live in the central areas of Pretoria in South Africa. It utilised the notion of successful ageing as a theoretical construct to examine how the women adapt to the challenges of old age. The study reveals that participants who had overcome difficult challenges in previous life stages by relying on their own resources are the most likely to adjust comfortably to the challenges of old age as well as the complexities encountered in the diverse central areas of Pretoria.
Key words: *Elderly, life course perspective, successful ageing, living independently, South Africa*

Résumé

Cette étude qualitative explore un vieillissement réussi parmi un groupe de vieilles femmes qui vivent dans les zones centrales de Pretoria en Afrique du Sud . Il a utilisé la notion de vieillissement réussi comme une construction théorique d'examiner comment les femmes adapter aux défis de la vieillesse . L'étude révèle que les participants qui ont surmonté des défis difficiles dans les stades de vie antérieures en se fondant sur leurs propres ressources sont les plus susceptibles de régler confortablement aux défis de la vieillesse ainsi que les complexités rencontrées dans les zones centrales de divers Pretoria .
Mots clés: *personnes âgées , la perspective de parcours de vie , vieillissement réussi , vivent de façon autonome , l'Afrique du Sud*

Introduction

Over a decade ago, the United Nations (2002:1) noted that:

> We celebrate rising life expectancy in many regions of the world as one of humanity's major achievements. We recognize that the world is experiencing an unprecedented demographic transformation and that by 2050 the number of persons aged 60

> years and over will increase from 600 million to almost 2 billion and that the proportion of persons aged 60 years and over is expected to double from 10 to 21 per cent. **The increase will be greatest and most rapid in developing countries where the older population is expected to quadruple during the next 50 years.** This demographic transformation challenges all our societies to promote increased opportunities, in particular opportunities for older persons to realize their potential to participate fully in all aspects of life (emphasis added).

This observation alerts us to the issue of old age. In Africa, reportedly characterised by youthful populations (World Development Report 2007: 33) the old age population is, nevertheless, growing. It was estimated that the number of Africans aged 60 and older would increase from 38 million in 2000 to 212 million in 2025 (Apt 2001: x). In South Africa, there are 4 million people above the age of 60: those between 60 and 64 years were 3 million in 2011 Stats SA) and those above 65 years were reported to have grown significantly from 4.9% in 2001 to 5.3% of the total population in 2011. In the City of Tshwane, which is the focus of this paper, the percentage of people older than 65 years grew from 4.1 to 4.9 per cent from 2001 to 2011 (StatsSA 2012b: 5).

With such an increasing number of people reaching an advanced age, many issues arise, in particular, the issue of suitable accommodation arrangements. In 2001, 2.1 out of 2.2 million people over the age of 65 years lived in household units in South Africa (StatsSA 2005:177). Of these, affluent elderly people in South Africa live in gated retirement villages (Goldhaber and Donaldson 2012a & 2012b) while the elderly poor, who often, acts as a resource person (financially – due to old age grants) tends to live within the family households (see for example Kimuna & Makiwane 2007). A general observation is the sharp increase in what could be referred to as collective living quarters (including old age homes and institutions) for the elderly. A significant number of white women live in such establishments (StatsSA 2005:178). One of the critical issues of concern in this regard is that African governments, including South Africa, can hardly afford to institutionalise large numbers of older people if they were to become frail, and families are not always willing or available to take care of them either. In recognition of this, perhaps, the South African Older Persons Act no 13 of 2006 (Department of Social Development 2006:8) advises that there should be a "shift [in] the emphasis from institutional care to community-based care in order to ensure that an older person remains in his or her home within the community for as long as possible". Given this, this study focused on elderly people living in age integrated communities (not old age homes. The key research questions are:

What constitutes successful ageing for elderly women living independently in a dynamic social environment such as the Pretoria central areas?

The aim of this article is to add insight to the life world of elderly people living independently (not in old age homes or with adult children) by focusing on 12 elderly women who live alone in central areas of Pretoria (for this research comprising of the inner city, Sunnyside, Arcadia and Capital Park), South Africa.

Alpaslan (2011), with students as fieldworkers, gave a baseline overview of elderly residents living in Sunnyside (some in old age homes) where he commented on the resilience of elderly people in this particular area. Although resilience has become a very popular theoretical construct to help understand how people cope with adverse life experiences (Wagnild 2003), a theoretical approach that has been associated with gerontology studies for a long time, namely successful ageing (see Alley, Putney, Rice & Bengston 2010), will be employed in this article to add richness to the analysis of the elderly. Another term, namely *supercoper*, is also used to show the complexities of successful ageing in particular contexts. In this study, successful ageing is not analysed by focusing on indicators of functioning (such as Activities of Daily Living; see detail below), but, rather, by focusing on the ability to adjust and cope with the demands of old age. This is known as the dynamic adaption process, an ability that may be better understood if previous life experiences are taken into consideration, implying the inclusion of the life course perspective.

2. Background

The abovementioned central areas of Pretoria have been specifically selected for this study, since they have been described as a haven for older people in the past (*cf* Alpaslan 2011: 114-116). The advantages of living in the central areas of Pretoria include most amenities being within walking distance and a bus service. Choosing these central areas as a place of residence is therefore practical, especially when one does not drive a car, cannot afford a car, or is no longer driving because of health risk factors. These areas have been a popular choice for elderly white people to live in for decades. Those from other racial categories were legally prohibited from settling there during the *apartheid* years (Van der Burgh *et al.* 1983). The enforcement of the Group Areas Act of 1950, in particular, resulted in people of different racial categories living in separate areas in South Africa.

After the abolition of the Group Areas Act in 1991 and the first democratic elections in 1994, South Africa underwent remarkable political changes, which dramatically affected the demographics and character of the capital city, Pretoria. Within less than two decades, the former "white only" Pretoria central areas changed to a population with an overwhelming number of black residents.[1] In addition, high numbers of foreigners from various other African countries have also moved into the central city areas during the last decade. As more and more black residents moved in, large numbers of white people moved out.

1 *According to the 2001 census, one of the central areas, Sunnyside, comprised of 60 per cent black, 3 per cent of mixed descent, 2 per cent Indian/Asian and 34 per cent white residents.*

Today, the central areas of Pretoria has a negative image because it is riddled with crime, overcrowding, deterioration of buildings, high noise levels, litter and poverty. This negative image is similar to a Johannesburg study (Ferreira & Rip 1990) more than two decades ago, which was highlighted by Alpaslan (2011). The deterioration of certain buildings in the Pretoria central areas is noticeable; so also is the overcrowding of specific apartment blocks. The methodology of the study is outlined below followed by a discussion of the concept of successful ageing and the findings.

3. Methodology

The research population for this study was those who live in one of the central areas of Pretoria in a household where they are not dependent on their adult children. People living in old age homes were excluded since they live separately from people in other age categories for most of their day and many services, such as preparing of meals, are delivered to them.

Since in-depth information on the lives of research participants meeting specific criteria was sought, a qualitative research design and purposive sampling (see Babbie 2013:129) were decided upon. I approached three resource people working in the central areas of Pretoria (a city councillor, a medical doctor and a social worker) and an organisation called Pretoria Care of the Aged. These four contact points yielded twelve women who were willing, available and able to be interviewed after which the great number of noted similarities in the interviews indicated that saturation was reached (see Sandelowski 1995).

With non-probability sampling methods a biased sample may be obtained and, in this particular sample, the racial and gender aspects are particularly noteworthy. Eleven of the twelve women were white and one was Indian. This is not an unexpected racial division, since black people moved gradually to the Pretoria central areas after the demise of apartheid. Most people move to cities for better socio-economic opportunities and, therefore, large numbers of elderly black people will most likely not form part of such intra-migration to the city. Apart from the racial bias, no elderly men were willing to be interviewed. Again, this is not surprising since there are fewer men in these age categories; but, more specifically, only two men, out of a total of approximately 20 people, attended sessions held by the Pretoria Care of the Aged and no other contact details for men could be obtained. Apart from racial and gender biases, Blodgett, Boyer and Turk (2005: par13) point out that purposive sampling may result in encountering a certain type of personality who tends to be more outgoing, social and friendly but they may also be informative research participants on certain topics since they have various social contacts.

3.2 Research interviews and ethics

I conducted all twelve of the interviews and transcribed them over a period of five months during 2010. The research participants were all interviewed in their homes or at a community centre, after appointments had been made via telephone/mobile phone or through a resource person at *Pretoria Care for the Aged*[2]. All the research participants gave their informed consent to take part in the research and have their interviews audio-taped (willing participants with illnesses that affect cognitive functions, such as Alzheimer's, were not interviewed as I am not qualified to ascertain whether they would understand what informed consent implies). The research participants were assured of their right to withdraw from the interviews or refuse to answer specific questions at any time. They were assured that their participation would be anonymous and therefore only pseudonyms are used in this article. The audio-recorded interviews were held either in Afrikaans or English (depending on the home language of the research participant), transcribed, and the relevant sections from the Afrikaans transcripts were translated (since I was the sole researcher, I consulted others, who are also fluent in Afrikaans and English, on the translation of certain vernacular expressions).

The discussions were relaxed and in certain cases included drinking tea, showing me photographs/documentation related to leases and newspaper clippings, interruptions by visitors/telephone calls, and tours through apartments or apartment buildings. I used an informal conversation style in the interviews, and the research participants provided most of the information I wanted to explore without my having to probe. A balance was struck between formality (since I came from a well-known university with a specific purpose) and familiarity (since I spoke their home language and live in the same city), which seemed to be conducive to in-depth interviews in which open and frank discussions were held; I was even let in on family secrets in one case (although I was requested to switch off the audio recorder beforehand). I was always mindful of the fact that research participants construct their experiences for my benefit in a particular manner and that they may even disclose information that should be kept confidential, as they may feel regret after an interview for divulging too much about themselves to a stranger. As is often the case, the ordinary aspects of their lives may be more insightful than their secrets (*cf* Blodgett et al. 2005: par 13-14; Mason 2003: 7-8; Silverman 2001: 300-301).

3.3 Data analysis

The transcribed interviews were analysed by making use of thematic coding (Babbie 2013: 396-398; Neuman 2003: 441-444). Certain of the identified themes from this coding process resonate with those identified by Alpaslan's (2011) research on the elderly

2 An active NGO focusing on elderly people living independently in the Pretoria central areas.

in Sunnyside for example references to crime. These themes are briefly highlighted in the next section after which case studies are presented in more detail to demonstrate the complexities of living independently, coping with the challenges of advanced age and a changing socio-historic environment.

3.4 Research profile

Of the twelve research participants who were interviewed, eleven lived in the central areas of Pretoria and one had moved out of the area two years prior to our interview. The latter was included in this study to gain some perspective on alternative choices for elderly women. With the exception of one Indian research participant, who moved recently from Durban to Pretoria, each of the research participants has lived in Pretoria for more than fifteen years, but only two have lived in Pretoria throughout their lives.

The ages of the 12 research participants vary greatly, with the eldest being 92 years old. Five women were in their eighties, two in their mid-seventies, two in their sixties and the remaining two were 54 and 59 years old. Chronological age on its own is not a good indicator of "old age"[3], since various other factors, such as health and socio-economic circumstances, impact greatly on the experience of old age (Baltes and Smith 2003). In this particular study, the research participants were identified by others (resource people) as "elderly people"[4] (these identified people were all 80 years of age and older) or they regularly attended meetings held by *Pretoria Care for the Aged*.

Five of the women were widows (three had outlived two husbands), two were married, one was single, and four were divorced (including one who had been divorced twice). Apart from Mrs Hugo, who has moved in with her children, two other women also mentioned that their children wanted them to move in with them, but they prefer to live alone, and it is clear that independence is regarded as a core value of their existence. Seven of the women in this study are partly dependent on food parcels and other material support from the state and welfare organisations in order to make ends meet.

4. Successful ageing

Over the last few decades, advanced ageing population structures in certain regions of the world (e.g. Western Europe, Japan and Northern America) intensified the attention paid to later life. Research on ageing within bio-medical, psychological and social disciplines has proliferated. Concomitantly, theoretical approaches abound in this field, as seen in the increasing use of theories by empirical researchers (Alley et al 2010).

3 *For this reason the complex old age categories such as 'young old' and 'old old' or the 'third' and 'fourth age' were not used.*

4 *The term 'older persons' is preferred by the United Nations but this term is confusing in everyday conversations since people may ask 'older than whom?' whilst terms such as elderly and aged are understood and used by research participants and resource people. For this reason the term elderly has been retained in this article.*

Within this growing field, successful ageing models have come to the fore as a tool to evaluate the level of functioning amongst older people.

The term successful ageing was originally proposed by Rowe and Kahn (1987), who wanted to break the practice of distinguishing only between pathological and non-pathological classifications of old age. The authors distinguish between usual and successful ageing and noting that both are non-pathological states. Rowe and Kahn (1997: 433) define successful ageing as "including three main components: low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life". Rowe and Kahn (1997: 433-34) elaborate: "interpersonal relations involve contacts and transactions with others, exchange of information, emotional support, and direct assistance. An activity is productive if it creates societal value, whether or not it is reimbursed."

Bryant, Corbett and Kutner (2001: 928) expound how successful ageing has often been quantified, also in South Africa (*cf* Møller & Ferreira 1992), by focusing on specific variables such as activities of daily living (ADLs). ADLs refer to basic physical activities, such as feeding oneself and dressing. Instrumental Activities of Daily Living (IADLs) include more elaborate activities that may require interaction with a wider range of people, such as shopping, managing money and going to places beyond walking distance. "Individuals can be 'graded' along a continuum of number and type of ADLs and IADLs they can perform without help" (Rubinstein, Kilbride & Nagy 1992: 16). However, it is generally agreed that successful ageing implies more than counting what people can do for themselves, and many quantitative studies include a section on subjective assessments of wellbeing or quality of life (*cf* Moen, Dempster-McClain and Williams 1992:1616; Schulz & Heckhausen 1996:704). In this study, none of the research participants experienced problems with ADLs, and most of them could comfortably engage in IADLs. This implies a further interrogation of what is meant by successful ageing.

Despite the widespread use of the term successful ageing, it is fraught with difficulties. First, a certain value judgement is implied if a term such as successful ageing is employed, which easily leads to a "Foucauldian gaze". Often the life-worlds and preferences of specific older people are ignored in striving towards an ideal of activities amongst the elderly as it is believed that what active older people do (regardless of what "active" exactly means and whether it is indeed desirable) constitutes successful ageing (Katz 2005: 123-130; Schulz & Heckhausen 1996: 704). Furthermore, empirical problems arise with the use of successful ageing models since clear conceptualisation of the term is difficult, partly because researchers from various fields employ discipline-specific terminology without critical reflection. In addition, notions of successful ageing are culturally specific and lay people's views on what constitute successful ageing also differ from those of researchers in that lay people emphasise a greater number of domains of successful ageing (Bowling & Dieppe 2005: 1550; Hung, Kempen & De Vries 2010: 1382; Schulz & Heckhausen 1996: 702).

A different approach to successful ageing is employed by Bowling and Dieppe (2005: 1549), who claim that successful ageing is an adaptive process that develops over one's life course when one is able to use past experiences to cope with current life circumstances. This process of adaptation resonates with the term "supercopers", which was coined by Bould, Sanborn and Reif (1989:78). These authors use this term to indicate how people may age successfully despite diminished capabilities. Once individuals lose the ability to do certain things for themselves, they have to adjust to these new circumstances and allow other people to help them, instead of stubbornly clinging to independence. This process is known as the **dynamic adaption process**.

Although this description of successful ageing is employed in this study (as stated in the introduction), it will be demonstrated below that such an understanding of successful ageing is not necessarily straightforward in that there is sometimes a thin line between being a "supercoper" and being unrealistic about one's coping abilities. Examples will be analysed to demonstrate the complexities of embracing successful ageing, and through an overview of major life events, a picture emerges of how diminishing capabilities, life transitions and challenges are dealt with. It will be argued that being a "supercoper" is easier if it is preceded by a lifetime of dynamic adaptation, which implies the importance of a life course perspective.

The life course approach adds value to successful ageing constructs by focusing on individual life trajectories, the current social context and how the ageing process is experienced within a specific period of history (*cf* Elder 1978: 26; Bengston, Putney & Johnson 2005: 14). In examining the relationships between the life course approach and successful ageing, the importance of trade-offs in later life (Schulz & Heckhausen 1996: 706) and multiple roles (Moen et al. 1992:1620) have already been identified. Trade-off refers to choices throughout life where investment of time and effort in a particular activity implies that less time can be spent on other activities. Moen et al. (1992:1632) found that involvement in multiple roles earlier on in life seems to promote both social integration and health in later life.

5. Findings: Supercoper?

Some participants in this study made comments or decisions that may appear as if they are ignoring the harsh realities of their vulnerable positions in the city and being unrealistic about their current life circumstances. The following six examples illustrate this point: Mrs Jolene Blom had a death threat from a tenant in the apartment block where she is a caretaker. She brushes this threat aside, and furthermore makes comments such as: "I believe the heart attack I had the other day is utter nonsense". Mrs Jennifer Moodley noticed that people come into her room and move things around when she is not there and she did not report this to anyone. Mrs Bea Daniels was chased away from her car guarding job by young male black car guards and she and her husband are gradually selling their furniture and appliances to make ends meet. Mrs Pat Miller and her adult son lived in a building that is rapidly deteriorating (the building has in fact been declared unsafe and officially closed in 2011) without actively trying to find alternative accommodation. Mrs Sally Rogers, who tried to commit suicide a few years prior to the research interview, prefers to know as little as possible about her serious illness, which will likely leave her paralysed within a few years. Mrs Evelyn Hendricks has no financial means or practical plan for a future if she may become frail or ill: she says: "I just hope I'll die in my sleep". All six women have financially independent children; but information regarding threats to their safety or health is either underplayed or withheld from their children.

At first glance it appears as if none of the participants above can be regarded as supercopers, since they ignore stressful aspects as much as possible; whereas a supercoper would be expected to deal with the stressor in a realistic manner. However, all these women have complex life circumstances and if a richer life story is provided, it becomes clear that they are adapting constantly to changed life circumstances. For example, Mrs Daniels and Mrs Hendricks are estranged from their children and Mrs Hendricks's daughter contributed to her dire financial position by leaving her mother in debt through fraudulent credit card use. One of Mrs Miller's two sons has been convicted of crime; her second son appears unable to live on his own for long periods and she lived with her daughter and her family for a few weeks when she had a foot operation. Mrs Moodley is on the verge of emigrating to Australia, where she will join her children and Mrs Blom, who has a serious heart problem, is considering moving in with her daughter, whose husband is a cardiologist. Mrs Rogers receives significant support from her sister, who lives nearby, and does not want to place additional stress on her only daughter by focusing on her deteriorating health. Considering more detail about an individual's life demonstrates that is not always clear-cut whether they are supercopers or not. The case of Mrs Harding will be discussed to illuminate this point

Mrs Pauline Harding (92) underplays her health problems, despite the fact that she can barely keep her balance if she does not have her walking frame. Mrs Harding has lived in the same apartment for 42 years. She has no family members who live nearby and she seldom leaves the apartment. She has a few friends, but she prefers to attend to all her ADLs herself and only relies on others for IADLs (e.g. groceries are delivered to her door, and a maintenance worker at the apartment building is willing to run errands for her on a daily basis). She does not want to talk about her health and, when mentioning a clinic sister who visits her once a week, she says: "We only drink tea together".

When I ask her whom she will contact if she accidentally falls, it transpires that she has actually fallen a few times and that she then tries to cope with this on her own. She laughs when she conveys how she sat on a wooden tomato box to defrost her fridge and how the box's planks gave way beneath her. She fell into the box, and remained stuck there for some time before she managed to roll over and crawl around in order to

free herself. She believes that her closest friend, who is also an elderly woman and the caretaker of the building she lives in, would in any case not be strong enough to help her when she falls, and therefore it would be useless to telephone her.

Two stressful events have occurred over the past eight years; her second husband's health deteriorated after the first of these events and he passed away; her own health deteriorated after the second event. The first event took place in 2002, when some men followed Mrs Harding and her husband into their apartment and brutally attacked them:

> They [the perpetrators] kicked him and they jumped on him, you know he was weak and he walked slowly ... They tied me up with my hands behind my back, put a whole shirt down my throat.

A few years after this traumatic attack, Mrs Harding, at the age of 90, was in a serious car accident which resulted in her being hospitalised for a long time. She returned to live in her apartment again, but she had to give up driving.

Taking the above into consideration, it seems as if Mrs Harding has difficulty living on her own since her support structures do not seem adequate and she is physically vulnerable. She does not seem to fit the category of a "supercoper", since she struggles to accept her diminished capabilities. Yet a broader view of her life brings additional aspects to the fore.

Mrs Harding lost her first husband to polio when both her children were financially dependent. She continued farming on her late husband's farm. Many years later, she met her second husband on a golf course (she continued playing golf well into her eighties). They moved to Pretoria and she was employed in the retail sector at a junior managerial level for many years. She also visited one of her children in a prime coastal vacation area shortly before I met her. This trip entails a two-hour flight as well as at least two and a half hours driving to and from airports. Furthermore, she maintains her apartment without any help (even though she could easily afford domestic services) and the apartment is neat and clean with good security (which was upgraded after the criminal attack); she can effortlessly sit cross-legged on a chair; she provides homemade snacks for her friends at their weekly scrabble meetings in her apartment; her own paintings hang on the wall in testimony to an ongoing hobby; she plays Sudoku games; she is well-informed about current news ; and she is generally self-sufficient. Unlike some of the other women in this study, she does not have any financial problems (she had worked for the same company for a long period of time, and her second husband sold life insurance for a living, which probably both contribute to her current financial security), and she can gain entry into a specific home for the aged at any time she wishes. The fact that she has made contingency plans for when she cannot continue living on her own, and that she indicated that she may not be able to cater for the weekly scrabble meetings any longer (both her friends, who came to visit her while I was there,

immediately agreed that she should stop this, as it is unnecessary), do indicate some preparedness to accept a life stage that may include greater dependency on others.

In focusing on only certain aspects of this participant's life, a bleak picture may be painted, but if her previous successes in overcoming hardships, her recent unusually high levels of activity for a woman of her age, her network of friends and other support people, and the fact that she does ask for help from time to time are taken into account too, an entirely different situation emerges. Striking a balance between doing as much as possible for herself for as long as possible while being able to ask for help and accepting changed circumstances, may thus imply being a "supercoper", or exemplify successful ageing.

6. Life as a dress rehearsal for old age

Out of all the research participants, only Mrs Karin Hugo, Mrs Daphne Coleman and Mrs Anne Thompson described a happy childhood, stable marital relations and secure financial positions throughout their lives. Although Ms Marinda Pienaar never married and lost her mother at a young age, she also described a happy childhood with a loving father and secure employment with good retirement benefits. The remaining eight women lived through profoundly stressful events such as difficult childhoods, traumatic divorces, gross unfair gender employment practices, poverty or estrangement from their children. Brief details are provided of the four most extreme examples of participants with difficult family relationships and low incomes.

Mrs Sally Rogers, together with her siblings, was removed from her parents' care and placed in an orphanage. When she finished school and left the orphanage, she met her husband, married him within a few weeks and became pregnant. A few years later she was widowed after her husband died from poison encountered at work (three people in the same office died from the same poison after short illnesses).

Mrs Evelyn Hendricks's father passed away when she was ten years old and her mother repeatedly told her that she would never be able to attain much in life. At the age of 16 she tried to escape an unhappy childhood by marrying a soldier who was returning from the Second World War. Unfortunately he became involved in crime and they had to move regularly because he was wanted by the police for fraud. When she left him, he gained custody over the children through tricking the authorities and then fled with the children to a neighbouring country before she could prevent him through a court order. Her later attempts at reconciliation with her children when they were adults did not succeed due to different values to hers having been installed in them at a young age by her husband (the credit card fraud by her daughter was mentioned above).

Both Mrs Bea Daniels and Mrs Pat Miller grew up in families where their fathers abandoned them, they both married men at a young age whom they divorced after

stormy relationships that included emotional and verbal abuse (Mrs Daniels remarried later). Mrs Miller is estranged from one of her sons, who has a criminal record. This son has also broken into her apartment on previous occasions. Mrs Daniels's children were removed from her custody when they were very young and she could never establish close relationships with them after this removal, despite numerous attempts at contacting them.

These adverse life circumstances have left Mrs Daniels angry and bitter. She describes herself as being "a hard person" who has little trust in others. She gave numerous examples from her life in which she almost immediately retreats from relationships if people appear unkind towards her or her plight as a poor person. Mrs Daniels walks many kilometres to access health care and obtains food parcels that she has to carry back to her apartment afterwards and she is developing hip problems, which occasionally makes this difficult. Yet she never asks for help. In contrast, Mrs Rogers, Miller and Hendricks portray themselves as sociable and outgoing people; but, in reality, none of them has close friends to whom they can turn for support. All four women describe various ways in which they provide support to others, but with the exception of Mrs Daniels's husband and Mrs Rogers's sister, they cannot really count on anybody in times of need. Although all four of them attend meetings for the elderly, they informed me that nobody at these meetings knows their life stories or about the days without food or other necessities.

Strained family relationships and poverty thus complicated their ability to adapt to new challenges associated with old age, such as deteriorating health and mobility. Overcoming hardships earlier on in life may change one's perception of what successful ageing implies. For certain research participants, being able to reach a destination, not being hurt by a partner or child or having enough to eat may very well constitute successful ageing if major life stressors earlier in life are taken into account.

In the next two case studies the importance of previous life decisions for current life circumstances are highlighted. These two participants were chosen since neither poverty nor abuse from family members has been encountered in their lives and therefore the demands of old age and living in the Pretoria central areas are more focal. The two participants, Mrs Karin Hugo (82 years old) and Ms Marinda Pienaar (80 years old), lived close to one another for years (probably without ever meeting each other) and attended church services at different churches in close proximity:

Mrs Hugo, a well groomed widow, moved out of her apartment to live with her children two years prior to our interview. She lives in a separate flatlet that is attached to the main house where her son and his family lives in a quiet, well-off neighbourhood. Her daughter and retired son-in-law live next door to her. The houses and garden are in immaculate condition (I was taken on an extensive tour through both houses to view tapestries created by her daughter) and Mrs Hugo's furniture, tea-cups and clothes suggest material comfort. Apart from a new hearing aid, which bothers her a little, she is in extremely good health;

she walks briskly and almost jumps out of chair when she gets up. She lived for 17 years in an apartment in Sunnyside, a Pretoria central area. She moved there from a rural area approximately a year after the death of her husband. She remembers the years of living there fondly, particularly her freedom to move around, since most amenities were within walking distance, and she had given up driving when moving to Pretoria. She does not regard herself as particularly socially inclined, but her mid-morning run of daily errands is described as one of the highlights, since it enables her to meet various people with whom she could have a quick chat. On Sundays she attended church services only a short walk from her apartment. When asked why she moved out, she answers:

> If I could still live there, I would have, because I can still do everything for myself, but circumstances changed too much there, because you know, when I moved in it was only white [referring to racial categories], and all of us lived marvellously in Sunnyside. It was a very nice place to live in, but over time things changed and it is actually just black there now and that is why I moved. The children also did not want me to continue like that because for every white that moves out there, a black moves in, and they are not alone you know.

She is unsure whether any of her former black neighbours had come from other African countries, and she had been only on greeting terms with black residents in her building. She also pointed out the increased noise levels (especially the *vuvuzelas* – loud instruments blown especially during and after football/soccer matches) and littering in the streets that bothered her. She maintains that she had heard that it was not worth the trouble to phone the police on such occasions because they no longer did anything about noise pollution.

Moving in with her children has changed her lifestyle dramatically. She lost contact completely with her earlier acquaintances and has almost no contact with one good friend who had lived fairly close to her:

> No, you know it is an adjustment because the thing is uh there, every morning once I cleaned the apartment and got dressed then I was on my way, then I go and do shopping and so, and there are always people you can chat to. So it was actually more of an adjustment here, because I am more left to my own devices, because I live here with my son and daughter-in-law and they both work, so I am alone here. But just next door, there is my son-in-law … my daughter also works, now if my son-in-law and I want to talk to each other, then we do and if we don't feel like it then we don't have to see each other.

Mrs Hugo's children had regular contact with her whilst she lived on her own and she had spent many weekends with them. She also explained how well her husband had looked after her, which is the reason for her current financial independence. She has never been employed: "No, no, he [her husband] never wanted me to work, he said that I should raise the children."

In contrast to Mrs Hugo, Ms Marina Pienaar never married and has no children. She has lived in the same apartment block for 37 years. She has two siblings living in Pretoria. She is originally from a small town, and she came to Pretoria to further her career as a librarian, which included studying at one of the tertiary institutions in Pretoria. She is in good health and mobile – she suggested that we use the stairs to her apartment since the lift is too slow for her liking, and she climbed the flight of stairs without any difficulty. She does not have many friends, but she has part-time work for three days of the week (in a field that is related to her previous career), she reads widely, and she watches sport and films in her spare time. She has almost weekly contact with at least one of her siblings, and she often visits them by using the bus service (she has never learnt to drive). Her younger brother does minor repairs in the apartment for her, and he and his wife are also the first people she contacts if she needs help. She had an accident a few months prior to our interview in which she injured her shoulder, and she manages pouring the tea without spilling only with difficulty. The apartment is somewhat neglected. She purchases some of her meals from a nearby old age home when she wishes to.

When asked about the racial composition of the apartment building, Ms Pienaar states with certainty from which countries the foreign residents come and from which towns the South African residents come. An example of her relations with other residents is a young Xhosa- speaking neighbour who comes to check on her every morning before leaving for work. Ms Pienaar has lived in the building for so long that she not only knows the current cleaning staff, but also the father of one of the staff, who passed the position on to his son. She is on the managing committee of the apartment building and is quite aware of all the rules and applicable municipal by-laws. She has telephoned the Police Department as well as the Fire Department on occasion to report a noisy neighbour who was entertaining a number of friends with, according to her, an illegal barbeque. They had been told by the officials to break up their party, and they did so within half an hour.

In comparing the lives of these two women, a few similarities are apparent: they are more or less the same age, they are financially independent, and they are both healthy and agile for their age. They both moved to Sunnyside after having lived in much smaller towns in other provinces, although Ms Pienaar had moved there and lived on her own from a much younger age than Mrs Hugo. They both describe themselves as not particularly socially inclined in the sense that they do not often receive visitors and neither do they visit others much. They both witnessed the same rapid socio-political changes and urban deterioration in their immediate vicinity, but their reactions to these changes are quite different – Mrs Hugo moved away, whilst Ms Pienaar is integrated into her environment by still being employed, serving on the

management committee of her apartment block, and knowing her neighbours regardless of their racial category. Clearly their different family circumstances play a big role in their differing life experiences, in that Mrs Hugo's children persuaded her to move in with them, but Ms Pienaar had no such options. However, Ms Pienaar could move into an old age home (very close to her apartment) at any time she wished, but she resisted this fiercely, maintaining that she is "not ready" for such a move.

At the time of the interviews, Mrs Hugo lived in much more attractive surroundings, with a well-kept garden and house, while Ms Pienaar's flat suggests the absence of regular maintenance such as painting. Yet, Ms Pienaar is able to live a full and active life in the way she chooses, while Mrs Hugo feels isolated, with little intellectual stimulation. Mrs Hugo experienced the changes in the nature of the city as threatening and difficult to cope with, and she believed that the Police Service would not defend her rights, even though she has never tested this view. Ms Pienaar, on the other hand, took the changes in her stride (e.g. buying ear plugs in preparation for the World Cup); she telephones the Police Department when necessary, and she has managed to foster good relations with a much younger black neighbour, which suggests caring.

The life course perspective helps to explain the two women's different levels of adjustment to challenges in later life. Ms Pienaar could adjust much easier to the changed nature of the city due to the fact that she is much more used to relying on her own devices and had came into contact with various people over the years, due to her occupation, Mrs Hugo enjoyed some independence, but major life decisions (such as not being employed or where to live) are made in consultation with or even at the insistence of family members.

The life stories of these two women emphasise that successful ageing is not a straightforward concept, since one could argue, on the one hand, that Ms Pienaar is in a worse situation than Mrs Hugo related to care and possible safety concerns. On the other hand, one could also argue that Ms Pienaar is in a better situation since she has substantially greater freedom to determine her own lifestyle, but still experiences care in times of need from her siblings, and has full availability of services at her doorstep, as well as the opportunity to foster and develop meaningful social relations.

7. Conclusion

The women in this study can generally be described as having aged "successfully" if quantifiable standards of successful ageing such as health, mobility and regular social contact with a variety of people are used as indicators of successful ageing. However, if the dynamic adaption approach is employed, certain research participants do not appear as supercopers who can adjust their lifestyles to changing circumstances. But, living in the central areas of Pretoria implies having to face challenges over and above those inherent in the ageing process. The rapid political and social changes in their

immediate environment over roughly two decades brought on new social dynamics in having to adapt living amongst people of different racial categories who may have diverse lifestyles and having to protect oneself against potential dangers such as criminal attacks. In addition, certain research participants experience added strains due to poverty and adverse family relationships. Such changes and added stressors impact on successful ageing, and the dynamic adaption process of elderly women informed by a life course perspective brought these added factors into focus. By employing a life course perspective, which includes a focus on a specific social context, it became clear that coping skills learnt earlier in life influence adaption strategies to later challenges in life. Having coped successfully with varied roles and challenges in previous life stages seems to ease facing the challenges of old age within a dynamic broader social context.

While it may appear at first glance that research participants are not adapting their lifestyles to accommodate financial difficulties and early signs of deteriorating health, a more detailed look shows how certain women are using exceptional coping skills by having to overcome far more obstacles than only stressors associated with advanced age. Trying to ascertain current levels of coping should therefore be informed by knowledge of previous life circumstances. Successful ageing is thus not a process that only starts with advanced age but rather a process that starts early in life and continues in old age.

References

Alley, D.E., Putney, N.M., Rice, M. & Bengston, V.L., 2010, 'The increasing use of theory in social gerontology: 1990-2004', *The Journals of Gerontology,* Vol. 65B, No. 5, pp. 583-590.

Alpaslan, A., 2011, '"Sunny side and/or shady side?": The living conditions and resilience of elderly Sunnyside residents', *Acta Academica,* Vol. 43, No. 2, pp.113-144.

Apt, N.A., 2002, 'Preface', In S. Makoni & K. Stroeken (eds.), *Ageing in Africa. Sociolinguistic and anthropological approaches* (pp. ix-xii). Hampshire:Ashgate.

Babbie, E., 2013, *The practice of social research,* 13th edition, Belmont, CA:Wadsworth/ Cengage Learning.

Baltes, P.B. & Smith, J., 2003, 'New frontier in the future of aging: From successful aging of the young old to the dilemmas of the fourth age', *Gerontology,* Vol. 49, No. 2, pp. 123-135.

Bengston, V.L., Putney, N.M. & Johnson, M.L., 2005, 'The problem of theory in gerontology today'. In M.L. Johnson (ed.), *The Cambridge handbook of age and ageing* (pp. 3-20), Cambridge: Cambridge University Press.

Blodgett, L.J., Boyer, W. & Turk, E., 2005, '"No thank you, not today": Supporting ethical and professional relationships in large qualitative studies', *Forum: Qualitative Social Research,* Vol. 6, No. 3, Art 35.

Bould, S., Sanborn, B. & Reif, L., 1989, *Eighty-five plus. The oldest old,* Belmont: Wadsworth.

Bowling, A. & Dieppe, P., 2005, 'What is successful ageing and who should define it?', *British Medical Journal,* Vol. 331, No. 7531, pp.1548–1551.

Bryant, L.L., Corbett, K.K. & Kutner, J.S., 2001, 'In their own words: a model of healthy aging', *Social Science and Medicine,* Vol. 53, pp. 927-941.

Department Of Social Development, Republic Of South Africa, 2006, *Older Persons Act* (Act no. 13 of 2006), Cape Town: Government Gazette.

Department Of Social Development, Republic Of South Africa, 2010, *Old Age Grant.* Available online at http://www.dsd.gov.za/index.php?option=com_content&task=view&id=106 [19/04/2010].

Elder, G.H., 1978, 'Family history and the life course', In T.K. Hareven (ed.), *Transitions, the family and the life course in historical perspective* (pp. 17-64). New York:Academic Press.

Ferreira, M., 2006, 'The differential impact of social-pension income on household poverty alleviation in three South African ethnic groups', *Ageing and Society,* Vol. 26, pp.337-354.

Ferreira, M. & Rip, S., 1990, *Social change in an area of Johannesburg: the case of elderly white residents,* Pretoria: Human Sciences Research Council, Co-operative research programme on ageing.

Goldhaber, R & Donaldson, R., 2012a, 'An 'age-regation' process as theoretical understanding of the gated retirement village', *Acta Academica,* Vol. 44, No. 3, pp. 1-23.

Goldhaber, R & Donaldson, R., 2012b, 'Alternative reflections on the elderly's sense of place in a South African gated retirement village', *South African Review of Sociology,* Vol. 43, No. 3, pp. 64-80.

Hung, L., Kempen, G.I.J.M. & De Vries, N.K., 2010, 'Cross-cultural comparison between academic and lay views of healthy ageing: a literature review', *Ageing and Society,* Vol. 30, No. 8, pp. 1373-1391.

Jackson, J.S., Brown, E., Antonucci, T.C. & Daatland, S.V., 2005, 'Ethnic diversity in ageing, multicultural societies', In M.L. Johnson (ed.), *The Cambridge handbook of age and ageing* (pp. 476-481). Cambridge:Cambridge University Press.

Kalache, A., Barreto, S.M. & Keller, I., 2005, 'Global ageing: The demographic revolution in all cultures and societies', In M.L. Johnson (ed.), *The Cambridge handbook of age and ageing* (pp. 30-46). Cambridge:Cambridge University Press.

Katz, S., 2005, *Cultural aging. Life course, lifestyle and senior worlds*, Peter Borough, Ontario: Broadview Press.

Kimuna, S.R. & Makiwane, M., 2007, 'Older people as resources in South Africa: Mpumalanga households', *Journal of Aging and Social Policy,* Vol. 19, No. 1, pp. 97-114.

Mason, J., 2002, *Qualitative researching,* 2nd edition, London: Sage Publications.

Moen, P., Dempster-Mcclain, D. & Williams, R.M., 1992, 'Successful aging: A life course perspective on women's multiple roles and health', *American Journal of Sociology,* Vol. 97, No. 6, pp. 1612-1638.

Møller, V. & Ferreira, M., 1992, 'Successful ageing in South Africa: opportunity structures and subjective well-being', *Southern African Journal of Gerontology,* Vol. 1, No. 1, pp. 5-8.

Neuman, W.L., 2003, *Social Research Methods. Qualitative and quantitative approaches.* 5th edition, Boston: Pearson Education.

Pretoria Care for the Aged, 2009, Available online at http://www.carefortheaged.org.za/about.html [20/04/2010].

Rowe, J.W. & Kahn, R.L., 1987, 'Human Aging: Usual and successful' *Science,* Vol. 237, No. 4811, pp. 143-149.

Rowe, J.W. & Kahn, R.L., 1997, 'Successful aging', *The Gerontologist*, Vol. 37, No. 4, pp. 433-440.

Rubinstein, R.L., Kilbride, J.C. & Nagy, S., 1992, *Elders living alone. Frailty and the perception of choice,* New York: Aldine de Gruyter.

Sandelowski, M., 1995, 'Sample size in qualitative research', *Research in Nursing and Health,* Vol. 18, pp. 179-183.

Schulz, R. & Heckhausen, J., 1996, 'A life span model of successful aging', *American Psychologist,* Vol. 51, No. 7, pp. 702-714.

Silverman, D., 2001, *Interpreting qualitative data. Methods for analysing talk, text and interaction,* 2nd edition, London: Sage Publications.

Statistics South Africa, 2005, *Census 2001. Stages in the life cycle of South Africans. Report no 03-02-46 (2001),* Pretoria: StatsSA.

Statistics South Africa, 2012a, *Census 2011. Census in brief. Report no 03-01-41,* Pretoria: StatsSA.

Statistics South Africa, 2012b, *Census 2011. Municipal fact sheet,* Pretoria: StatsSA.

Van Der Burgh, C., Theunissen, D.J.M. & Ferreira, M., eds., 1983, *White elderly persons living in the inner-city area of Pretoria: an exploratory study,*. Pretoria: Human Sciences Research Council.

Van Der Burgh, C. & Herbst, D., 1984, *Die lewensomstandighede van swart bejaardes in enkele blanke stedelike gebiede: 'n Verkennende ondersoek [The life circumstances of black elderly in selected white urban areas: An explorative study],* Pretoria: Human Sciences Research Council.

Wagnild, G., 2003, 'Resilience and successful ageing. Comparison among low and high income older adults', *Journal of Gerontological Nursing,* Vol. 29, No. 12, pp. 42-49.

United Nations, 2002, *Report of the Second World Assembly on Ageing*. New York: UN.

World Development Report, 2007, *Development and the next generation,* Washington, DC: World Bank.