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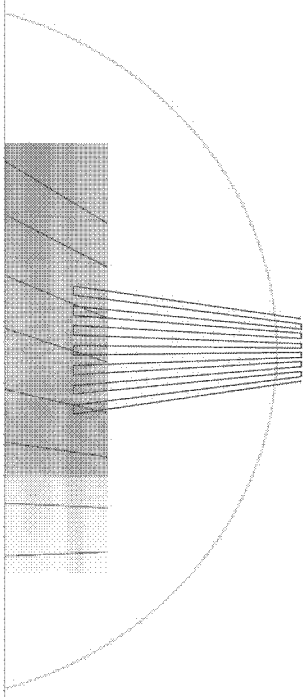
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Race, social transformation and redress in the South African social and health sciences

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Introduction

Alongside the media, public and policy sectors, the social and health sciences in South Africa have been a central site for negotiating the contested discourses on the role, nature, utility and longevity of race in post-apartheid South Africa (see for example Duncan, 2001; Durrheim, 2003; Franchi, 2003; Seedat, 2001; and Stevens, 2003). These sciences face an intractable paradox: They have to vigilantly act against the ever-threatening possibility of racialising the information and data that they generate and produce, and simultaneously remain cognisant of the historically skewed influences of race on the health of the population. This paradox is forcefully manifested in the footnotes that invariably accompany many publications from within the post-apartheid social and health sciences. Reports such as those from the National Injury Mortality Surveillance System (NIMSS),[2] which focuses on the magnitude of non-natural deaths related to violence and unintentional injuries, all seem to carry the following or similar caveats when engaging the use of race as a heuristic construct.

> While this report uses the term 'population group' and associated terms 'African', 'Coloured', 'Asian' and 'White', we recognise that 'population group' is a social construction that serves particular political purposes. The use of these terms in this report

> does not imply any acceptance of the racist assumptions on which these labels are based (Burrows, Bowman, Matzopoulos & Van Niekerk, 2001, p. 3).

In contrast, other finely printed footnotes on texts including job advertisements, predicated on racial constructs that assume the form and register of redress, make use of the categories African, coloured people, Asian and white people as employment equity targets, without explicitly problematising the use of such terms, even though there is an ongoing public debate about how best to deracialise South Africa's transformation agenda. This is evident in the following extracts:

> We have a career opportunity for a senior manager to manage the vendor relationship and service of their IT outsource company to the group. You would be employed by the corporate mining head office in Johannesburg... ONLY AFFIRMATIVE ACTION CITIZENS (Black, Indian, Coloured) ('Vendor/Outsource Manager' advertisement, 2004).

> The incumbent will form part of the management team responsible for Operations. The focus will be on methodology improving operations efficiently. The incumbent will also be responsible for managing staff... Position ONLY for BLACK MALE with management experience ('Operations Development Manager' advertisement, 2004).

While the use and deployment of race in the service of resource mobilisation, and access to welfare and socio-economic opportunities appear to be broadly countenanced and at times even encouraged, some research on race has revealed it to be an imprecise social and health measure and a flawed scientific construct. Many scientists have therefore called for the disaggregation of the race variable into more precise and measurable components, or the dissolution of the variable entirely (Taylor & Orkin, 1995). This kind of call is well-illustrated in the recent decision taken by the South African National Blood Service (SANBS) to scrap its policy of employing race to determine the level of risk for HIV/AIDS among blood donors. This decision was taken after the revelation that President Thabo Mbeki's blood was incinerated by the SANBS because he did not complete a mandatory questionnaire as a donor and that the SANBS disposed of black African and coloured people's blood because such blood was regarded as carrying an elevated risk for HIV contamination. The national scientists from the Medical Research Council (MRC) pointed out that race was a crude way of determining risk. President Mbeki's speech in Parliament on 24 June 2004 similarly seems to herald a renewed political shift and will to deracialise South African society and a 'determination to join hands fundamentally to transform our country into a true non-racial, non-sexist and prosperous democracy, in which the racist legacy of the past would have ceased to define us as Africans, Coloureds, Indians and Whites, giving all of us the possibility to be merely South African' (Mbeki, 2004, p.4).

In the wake of these public and academic developments, we attempt to further the contemporary debates on the deployment and use of the race variable in social and health scientific research in South Africa. Our analysis takes cognisance of the two

streams of thought that inform contemporary debates on race in South Africa. The first stream, which assumes a meta-theoretical approach and which is rich in theoretical argument (Taylor & Orkin, 1995), generally locates itself as being critical of the second stream, which represents the data-driven approaches to the study of health and race in South Africa. Our commentary attempts to critically assess the merits of each of these standpoints.

We begin by briefly reviewing some examples of research that make use of race in their examinations of the health and social life of South Africans and then proceed to highlight studies and issues that point to race as a proxy measure for a range of other socio-demographic variables. In the final section of our chapter, we take a critical look at some methodological and philosophical implications inherent in the effective deracialisation of social and health research in contemporary South Africa.

Race and health in South Africa

Research and trends on racialised patterns of health

South Africa's institutionalised history of racism has generated a substantial body of literature that examines the relationship between race, racism, and the health status of various groups (Phillips & Verhasselt, 1994; Wolman, 1998). This research has produced a large corpus of findings that are critical to understanding the racialised nature of social problems facing South Africa. For example, in a study on depression conducted in the early 1990s by Gillis (in Ferreira & Gillis, 1997), it was reported that rates of depressive symptomotology varied between 1.1% for white women and 15.7% for urban African women, while the rates for men from these population groups varied from 0.4% to 6.1% respectively.

More recently, Matshidze, Richter, Ellison, Levin and McIntyre (1998) found dramatic evidence of the impact of race on the rate of Caesarean section deliveries, indicative of both under- and over-servicing by race, regardless of whether women deliver their babies in private or public health facilities. In a study conducted during more or less the same period May, Woolard and Klasen (2000) found that the life expectancy for white women was 76, compared to 67 for African women; and 69 for white men, compared to 60 for African men. May et al. (2000) also reported that while the infant mortality for whites in the mid-1990s was 7 per 100 000 live births, it stood at 54 per 100 000 for Africans during the same period (May et al., 2000).

Focusing on the continuing racialised poverty trends in South Africa, May et al. (2000) also found that an average of 61% of Africans and 38% of coloured people were living in abject poverty, as compared to 1% of whites. Friedman (1999), who identified similar trends, found that 95% of South Africans who lived in poverty are classified as Africans. Furthermore, May (2000) established that while the average income for white households was R60 000 per annum, the average income for African, coloured, and Indian households was R12 400, R19 400, and R40 500 per annum, respectively.

Studies focused on early childhood development have highlighted that the effects of race on children's survival, health and well-being are discerned in every aspect of the lives of children and their families. The racialised effects begin prior to conception and continue throughout the periods of gestation and birth, both of which are strong determinants of later health and development. Indeed, an assessment of the current lived reality of South Africans reveals that race and racism remain central to social organisation in this country, and that access to social and economic benefits continues to be ordered along racial lines (May et al., 2000). For example, just four to five years ago the health, educational, and other support facilities to which the majority of African children had access were still significantly inferior to the facilities to which the majority of white children had access (Baldwin-Ragaven, de Gruchy & London, 1999; Biersteker & Robinson, 2000; Ministry of Education, 2001; Office of the Deputy President, 1998; Reconstruction and Development Programme [RDP], 1996).

Challenging racialised social and health inequalities

While there can be no denying that there is a strong relationship between race, racism, and ill-health or health promotion in contemporary South Africa (Budlender, 2000; May et al., 2000), there is also a need to critically examine the utility of race as the sole or even *the* key indicator in existing studies on infant mortality, disparities in health care, and equitable health provision.

Many studies have accordingly considered race as a compacting concept that serves as a proxy measure for a range of other variables, such as socioeconomic status, urban/rural location, language, and group affiliation. This tendency to use the variable as a funnelling concept may have concealed the significance of other variables relevant to understanding the health and social patterning of South Africa in general and the injury mortality profile of the country more specifically. For instance, while May et al. (2000) confirmed that racialised inequality continues to characterise the population of South Africa with between-race inequality accounting for 37% of total inequality, their study also revealed that within-race inequality, particularly within the white and African social groups, was also fairly substantial. The Gini-coefficient among African households was as high as 0.54; that is, nearly as high as the national coefficient, which is ranked among the most extreme globally. Such data are critical if we consider that racially constructed groups have traditionally been assumed to be homogeneous in their behavioural characteristics, health-seeking behaviours, overall health status and access to resources (Van Rensburg & Fourie, 1993).

Despite the obvious pitfalls associated with the use of the race variable internationally, research communities thus far have generally produced very little national and international research that attempts to critically examine the race variable and the link between race, mortality and health. Notable exceptions include research conducted by Barbarin and Richter (2001), Ellison, De Wet, Isjsellmuiden and Richter (1997a, 1997b, 1997c), Siefert, Heflin, Danziger and Williams (2000), Van Rensburg and Fourie

(1993) and Wolf, Gortmaker and Cheung (1993). For example, the race variable was problematised in a study reported by Wolf et al. (1993) on schoolgirls' weight. In this study it was found that race served as proxy for a range of other variables, including age and poverty levels. Similarly, Siefert et al. (2000) found that in many psychiatric epidemiological studies that investigated relationships between social status factors and psychiatric illness, race served as a proxy for various other invisible variables, such as age and levels of poverty.

The dangers of retaining race as a self-explanatory social category are epitomised by a lead article in the *Saturday Star* by journalist Siphiwe Mpye (20 September, 2003). In an attempt to debunk racist ideas about perpetrators of crime, Mpye wrote: 'The common face of hijacking in South Africa might be a young, gun-toting black man. But the reality is that high-powered puppet-masters behind them are mostly White or Indian' (2003, p. 1). The ensuing public reaction, indicative of a racialised public consciousness in South Africa (see Saturday Star, 27 September, 2003), re-focused the debate around race, racism, and the racial character of redress projects in the country.

So, treating racialised groups as homogeneous leads not only to the entrenchment of racial stereotypes (e.g. *They are all the same*) (Ellison et al., 1997a, 1997b, 1997c), but may frequently also contribute to certain segments (normally those in higher income and professional categories) benefiting more than the most needy from attempts to correct racialised patterns of inequality. Recent research and debate on how middle-class professionals frequently appear to benefit more from affirmative action processes in the workplace than lower income workers serve as another case in point (May et al., 2000). In 1991, 9% of the richest income deciles were black African. This figure rose to 22% by 1996 (Everatt, 2003). Thus, in the short space of five years, or more specifically in the short period of two years in which democratic economic redress and reform programmes were in operation in South Africa, the formerly rigid racialised lines of economic access and wealth were rapidly redrawn. Two years of government-driven programmes aimed at redressing racially skewed patterns of economic privilege had therefore yielded a 13% increase in upper income as represented by African South Africans.

Before we are tempted to infer that redress in the country has yielded deracialised equity in South Africa, we should note the illuminating fact that the 'poorest [South Africans] remain obdurately and overwhelmingly black' (Everatt, 2003, p. 79). In essence, while redress has realised a significant increase in upper-income African wealth, racialised poverty remains a reality for the majority of post-apartheid South Africans. What implications do these tensions hold for current and future research to be conducted in the social and health sciences? An uncritical and singular focus on race (even when the intention may be to redress racialised apartheid-generated distortions or possibly to challenge racialised perceptions) tends to unreflexively re-racialise our social responses to key issues such as crime, safety and health. Yet redress programmes aimed at rectifying the skewed racialised privileges of the past are imperative (Habib, 2003).

Removing race from social scientific equations: can we, should we?

Given that rising income in better-off African households has widened *intra*-racial inequality as well as reduced *inter*-racial inequality (Nattrass & Seekings, 2001), race can no longer simply be equated with socioeconomic status. International literature has revealed that socioeconomic status (outside of race as a grouping variable) is a viable predictor of health outcomes in many cases (Bollen, Glanville & Steckby, 1999; Cornish & Denny, 1989; Deonandon, Campbell, Ostbye, Tummon & Robertson, 2000; Higgs, 2002). Those belonging to the more advantaged groups tend to have better health than the other members of their societies. Furthermore, in a number of countries, these socioeconomic differentials are increasing (McLoone & Boddy, 1994; Pappas, Queen, Hadden & Fisher, 1993; Pearce, Davis, Smith & Foster, 1985; Whitehead, 1997).

While the literature suggests that socioeconomic status is a good indicator of the health status of any particular group, there is no agreement on a single indisputable measure for socioeconomic status (Higgs, 2002). This is largely due to differences in the nature and composition of economically stratified groups in any given population. For example, while Cornish and Denny (1989) unequivocally uphold social grade as the most appropriate demographic measure for a wide range of outcomes in Britain, Higgs (2002) understands wellbeing measures to be optimum units of measurement for developing countries. So, developing SES indices to displace the proxy function of race in social and health scientific research is not without its own challenges. Indeed, using different SES definitions as variables in social and health research has yielded very different results.

Varying results are unavoidable if one considers the underlying assumptions of the various SES measures in social and health research. For example, resource-based SES definitions refer to 'material and social resources and assets, including income, wealth, educational credentials' (Krieger, Williams & Moss, 1997, p. 345) and other elements that comprise the sample's immediate and present reality. Prestige-based measures in contrast refer to an 'individual's rank or status in a social hierarchy, typically evaluated with reference to people's access to and consumption of goods, services, and knowledge, as linked to their occupational prestige, income, and education level' (Krieger et al., 1997, p. 345). If one considers the examples of the employment equity advertisements presented earlier, then race in South Africa has high predictive validity for securing social and occupational prestige under a prestige-based SES definition. Potential rather than immediate access to material economic benefits would not be effectively captured by a resource-based SES definition that emphasises the individual's current lived economic reality. Deciding on replacing the flawed variable of race with the many variables for which it has hitherto been assumed to serve as a proxy is therefore not without its own ideological and pragmatic difficulties.

Pragmatic considerations

Perhaps a strategy for the dissolution of race as a variable of social and economic significance for research would involve the comprehensive collection of the requisite

social and economic information from an individual subject. However, the acquisition of such individual-based data is in itself fraught with difficulties. For example, studies on morbidity and population have shown that it is extremely difficult to obtain socioeconomic status data for individual injury victims, because of difficulties in accessing accurate information regarding these sensitive indicators (Burrows, Vaez, Butchart & Laflamme, 2003). Research subjects in these scientific studies are reluctant to divulge their annual household or per capita incomes and other indices of individual level SES. Studies that aim to establish the epidemiology of population mortality are at an even greater data disadvantage. National studies such as the NIMSS cannot readily acquire or establish the SES positions of their fatally injured subjects. In such cases, the researchers are forced to make use of area-based indicators of socioeconomic status. Reviews of studies suggest that community characteristics impact on population health and even have effects that are independent of individual, particularly socioeconomic, characteristics (Pickett & Pearl, 2001; Robert, 1999; Yen & Syme, 1999). However, since identifiers such as the victim's area of residence are not collected by the NIMSS, further information on the social and economic position of the subject must be extracted from police records in the mortuary.

The collection of area level data for South African mortality research is expensive and labour intensive. Yet such data are still far beneath the information quality that could be gleaned from the individual-based data gold standard. Deriving broad inferences from the area in which a person lived is not without its own methodological problems in South Africa where area of residence was unquestionably racialised by the Group Areas Act of 1950. Again, assessing whether area-level information has not continued to proxy for race requires (quite obviously) a concessionary recourse to the race construct itself. The paradox is endless. It appears that at this juncture in our aim to realise a non-racial, non-sexist society we cannot deracialise South African society without in some way having recourse to the primary social construct of race around which our society has been historically structured.

Conclusions

The use of race as a variable in post-apartheid social, economic and health science and in other areas of public life is characterised by three discernible methodological positions. The first unapologetically makes use of race as a variable to describe the characteristics of a population grouping that is believed to still embody the characteristics of a racialised South African population. The second calls for a dissolution of the variable entirely and advocates a greater focus on nonracialised characteristics of the population, such as age, class, and gender. The third position still regards race as useful in that it aggregates or proxies other variables that are suitably described by race as a broad grouping classification tool.

Each of these positions demands a subset of problematic locations for the social scientist and researcher in contemporary South Africa. If we make use of race as an *a priori category* and thus a self-contained variable in contemporary research, we

inescapably deny the plethora of evidence that suggests the dynamic and changing socio-economic nature of post-apartheid South Africa. By calling for the dissolution of the category altogether (Taylor & Orkin, 1995), we risk further disadvantaging the historically disadvantaged, those sectors of the population for whom redress has not proved beneficial and for whom race forms both an undeniable subjective reality and a means to objective material resources. If we consider race a proxy measure for other less visible elements, we risk re-racialising data that perhaps fall outside the very parameters of the proxy we believe race to measure. In short, the use, misuse or omission of race as a variable in post-apartheid South Africa is fraught with political promises, ideological ambiguities, and methodological inaccuracies.

Race as a continued reality for many

An assessment of the current lived reality of South Africans reveals that race and racialised patterns arising in its early colonial history and legislated in the apartheid era remain central to social organisation in this country, and that access to social and economic benefits continues to be ordered along racial lines (May et al., 2000). Thus, while greater focus on non-racialised characteristics of the population such as age, class and gender is important to fully explore the social patterning of health data in a population, the complete dissolution of the race variable would perhaps prove premature at this point.

The changing socioeconomic variables across time for some race groups and not others suggests, however, that research in the social and health sciences should not unapologetically make use of race as a variable to describe the characteristics of a population grouping in health disparities and mortality studies. Our illustrative analytical example provides insight into the inefficacy of regarding race as a stand-alone health denominator. Significant intra-racial changes indicate that the variable does indeed conceal a range of other determinants of health disparities and mortality (Van Rensburg & Fourie, 1993).

Race as a proxy measure

The unreflexive use of race as a proxy is, however, equally problematic in that it has the potential to efface the significance (both statistically and substantively) of various other variables, the identification of which might be crucial to addressing disparities as part of a larger health promotion drive.

It may be that race is useful in that it aggregates or proxies other variables that are suitably described by race as a broad grouping classification tool. However, the socio-economic variables used in the current NIMSS analyses, for instance, do not show any relation to race-based homicide rates. Reasons for the lack of significant associations are numerous. Firstly, income, education level, and occupational prestige were the only variables examined. Factors possibly constituting race are endless. This may suggest that the nature and composition of the population being measured should command

the specificities of its own measurement tool; and that in a diverse society like South Africa we may need to broaden our thinking as regards socioeconomic or other measures (Higgs, 2002). The lack of availability of individual level socioeconomic status data is problematic, and until such data are readily and continuously available, researchers may have to continue to use race. However, they should not do so uncritically. Even the use of area-based socio-economic status is not without difficulties. The lack of comparability across the 1996 and 2001 South African census data generated by Statistics South Africa (the centralised statistics department of the South African government) with respect to income means that this important aspect of socioeconomic status cannot be explored as a possible factor contributing to race differences.

Such findings demand that the conventional assumptions about race should indeed be interrogated and that conventional complacency regarding race as an unproblematic indicator or proxy indicator for social and health inequality should be challenged and questioned: Does race, as a variable, tell us enough about existing patterns of mortality, differential health and health care in South Africa? Does the race of a child tell the health facility everything about his or her health status and the design of health services for him or her? In our endeavours to address skewed patterns of health in South Africa, are we perhaps according too much explanatory influence to race as a denominator for all significant differences? Has the prominence of race in South African society and its dominance as an explanatory construct in South African research not perhaps limited the nature and quality of research about health patterns?

Representing, resisting and redefining racialised data: how, when and where?

If, as Apple (1993) asserts, race

> is not a stable category. It has changed over time. What it means, how it is used, by whom, how it is mobilised in social discourse, its role in educational and more general social policy, all of this is contingent and historical (Apple, 1993, p. vii),

then understanding the function or value of the use, misuse or omission of the race variable is a critical consideration for post-apartheid social and health research. If, whatever the race variable was believed to mean, represent or proxy has changed, then the task of the social and health sciences is to uncover methods to determine the existence or nature of that change *without* re-commissioning the *racialisation* of the very components that they are precisely attempting to *deracialise*.

Essentially, how does the researcher attempt to deracialise data *without* referring to the category of *race*? This is the conundrum with which contemporary social and health researchers in post-apartheid South Africa must consistently grapple. Indeed, investigations into the status and/or success of the processes of transformation and democratisation in post-apartheid South Africa are fraught with examples of paralysing political and scientific tensions when considering the inclusion of race as a variable. How

do health and social scientists measure the success and/or failure of the South African government's redress-driven strategies and policies aimed at rectifying racially skewed patterns of economic access and the attainment of health equity across the population of the country without using (or having recourse to) the very racial signifiers that informed the apartheid logic from which they were born? Furthermore, how do we measure the success of policies aimed at health and social equity policies without referring to race – the very category that was targeted for redress?

In short, we may need to concede to the need to use the category for progressive and possibly even liberatory purposes. Stated differently, our racialising means may just paradoxically justify deracialising ends. If we consciously engage race on its own terms, evidence-based approaches to its study may ultimately contribute to revealing it as a fabrication, a constantly shifting and sliding symbolic and politically motile illusion.

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Notes

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2. The NIMSS was developed in response to a lack of detailed epidemiological data in South Africa. The NIMSS collates information that arises from medico-legal post-mortem investigations. Demographic variables of the deceased, spatial and temporal details of the injury event, the manner and external cause of death, and the involvement of alcohol are recorded. All deaths due to external causes are included for all races, allowing an overview of how the different manners of death contribute to the profile of non-natural mortality in men and women, in the different race groups (as defined by the Population Registration Act of 1950) and across ages.