UNIVERSITY OF CAPE TOWN
FACULTY OF EDUCATION

HEALTH AND LITERACY: A STUDY OF LITERACY PRACTICES IN A DAY HOSPITAL IN THE WESTERN CAPE.

A DISSERTATION PRESENTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS IN PHILOSOPHY

JANE HARRIES
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ABSTRACT

Located in the Hout Bay Day Hospital, this research project focused on literacy practices as embedded in social context. In exploring how patients - both those regarded as literate and non literate - engaged with the discourses of medicine as represented by medical texts, symbols and artifacts, their constructions of identity, agency, voice and meaning within the medical domain were examined.

It was at the interface between the formal as represented by the medical institution and the informal, represented by individuals from within the community that diverse literacy practices were encountered. While individuals were dependent on the system for medical entitlements and treatment, they were able to rescript dominant medical literacies and technologies within the context of their own health and social needs. What was more important was not patients' encoding and decoding of medical texts but rather how they used their own socially embedded literacies to mediate and gain access to these health care entitlements and medical treatment and the discursive skills and resources that they employed in doing so. Uncovering the processes whereby patients were able to recontextualize their experiences of medical literacy and technologies in the context of their material and social realities was one of the key issues explored in this thesis.

The research findings suggested that a discursive boundary existed between patients' conceptions of health and illness and those presented by the medical institution. An understanding of patients' different discursive strategies and their social constructions was developed through ethnographic research methods. A socio-spatial analysis of 'hidden' literacy practices lead me beyond the confines of print literacy (alphabetic literacy and numeracy) and suggested differing ways of 'seeing' and 'reading' literacy, further broadening the concept of literacy to include body or somatic literacy. The manner in which the patient's body was 'read' and narrated as a text on entering the medical space was examined and interpreted. In addition, the way in which patients created their own space from within formal institutional space was discussed.

In conclusion I argue that the ways in which local knowledge is constructed by the recipients of health care needs to be explored and examined and that these constructions should be taken into consideration when planning future health care initiatives.

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ABBREVIATIONS

ABE	Adult Basic Education
ANC	African National Congress
COSATU	Congress of South African Trade Unions
CPA	Cape Provincial Administration
Dr.	Doctor
FN	Field Notes
MK	Umkhonto we Sizwe
NLS	New Literacy Studies
RDP	Reconstruction and Development Plan
SA	South Africa
SACP	South African Communist Party
Sr.	Sister
STD	Sexually Transmitted Disease
UCT	University of Cape Town
UWC	University of the Western Cape

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CHAPTER 1

CONSTRUCTION OF THE RESEARCH OBJECT : LITERACY PRACTICES IN A DAY HOSPITAL IN THE WESTERN CAPE.

1. Introduction

This thesis examines literacy as situated social practice within a specific setting, the Hout Bay Day Hospital. In this introductory chapter I outline my construction of the research object. This study began as an analysis of literacy practices amongst patients at the Hout Bay Day Hospital, the manner in which these practices intersected with the dominant discourses of medicine and how they were socially constructed and interpreted. As events slowly began to unfold I discovered that although most patients were able to read and write (a traditional construction of literacy), I seldom observed any reading and writing practices amongst patients in the day hospital, nor direct engagement with the medical texts, symbols or artifacts which I assumed were an integral part of the regulation of the bodies and health of patients. I was puzzled by this disjuncture, finding it difficult to explain in terms of my understandings of literacy.

I was faced with a dilemma since both literate and non-literate patients appeared to have distanced themselves from the formal literacies of medicine. A number of questions needed further exploration:

- If "illiteracy" is truly the "handicap" or "social disease" that certain development and modernization discourses would have us believe, why are literate patients not visibly engaging with texts ?
- Why do patients appear to become passive recipients of medical intervention once entering the medical space?
- And if so, how and why, are their literacy practices being delegitimated and marginalised by the medical discourses ?

My developing understanding of the concept of literacy became an epistemological journey and an autocritique of my own understanding and integration of the discursive constructions of literacy. The realization that literate patients were not visibly engaging with the medical texts, and that their literacy practices were perhaps embedded in other social practices required a re- examination and reformulation of my original research plans. I realized that I needed to approach my field site in a different manner requiring new modes of understanding and enquiry. This required a discursive move towards understanding **the body** as text as it was here that I sensed a form of disjuncture and dissonance in the manner in which patients related to medical texts and where the textual practices of the medical institution were most directly enacted.

The dilemma then was how to make the epistemological shift from literacy as depicted by the New Literacy Studies (NLS) in which the focus is on print literacy (alphabetic literacy) as embedded in social practice, to other and differing "readings" of literacy, particularly as it relates to the body. I hoped to achieve this by exploring the manner in which social bodies entering the medical space are socially and discursively constructed, so that the body is viewed as a text to be 'read' and 're-read' by the dominant medical discourse.

My own journey in exploring the meaning of literacy was influenced initially by the New Literacy Studies and locally by the SoUL (Social uses of Literacy) project at UCT and UWC. This approach was then expanded to include social theories of the body, which include works ranging from the French philosopher Michel Foucault to British sociological theories on the body, the anthropology of Mary Douglas, Robert Hertz and Marcel Mauss.

1.1 Theoretical and Methodological influences

This research project was undertaken under the auspices of the Department of Adult Education at UCT. Researchers in this department had participated in the SoUL research project which arose out of a concern about a paradox in the adult basic

education field in South Africa. More specifically, the problematic manner in which state sponsored discourses of redress and development appeared to be influenced by outmoded modernization and development models. The modernization model depicts the movement from illiteracy to literacy as an evolutionary progression having a direct causal relation to economic improvement and social mobility and endowed with the ability to redress the injustices and educational inequities of the apartheid era (Feldman,1995b). Within these terms a marginalised population of illiterate adults was constructed as illustrated by the following quote:

> It is estimated that about 15 million Black adults (over one third of the population) are illiterate and have had little or no education....The lack of access to basic education, including literacy and numeracy, has consigned millions of our people to silence and marginalisation from effective and meaningful participation in social and economic development (CEPD,1994,1;ANC 1994;7) in SoUL introduction (forthcoming).

Adult education classes aimed at redressing this imbalance however showed low enrolment and high drop out rates. The SoUL researchers' aim was to examine adult non- participation in literacy programmes. The research was conducted in differing field sites, both rural and urban and focused on foregrounding the real life experiences and social practices of the recipients of literacy provision rather than the perspectives of the providers of literacy. The SoUL research project documented a typology of strategies that unschooled adults used in their informal acquisition of literacy skills in everyday life practices.

This section presents a summary of the theoretical influences that have been drawn on in developing a conceptual frame for this research and for providing the theoretical language for analyzing the research data obtained in the field.

In framing research questions and in deciding on methodology I was initially informed by the body of research and theory that has been called the New Literacy Studies [1], which has led to the deconstruction and subsequent reconstruction of the

[1] The work of Street (1984;1993) in anthropology, Scribner and Cole(1981) in psychology, Brice Heath (1983) and Gee(1990) in socio-linguistics have been formative of this new field. Other more recent studies have provided accounts of literacy practices in specific contexts, Barton and Ivanic(1991) and Baynham (1995).

definitions and boundaries of literacy. The main focus of this study is **literacy practices** (Barton, 1994; Baynham, 1995; Street, 1984). The conception of literacy practices rather than literacy *per se*, arises out of research done within the **ideological model of literacy** (Street, 1993) and within the New Literacy Studies. In this approach literacy is viewed as an ideological and socially embedded practice within particular social contexts.

I draw on the concepts of literacy practices, literacy events, narratives, voice and mediation ; drawing from the works of Street in anthropology (1984;1991;1993), Brice Heath (1983) and Gee (1990) in socio-linguistics, Barton (1994) in ecology of literacy, and Baynham (1995) in literacy practices and literacy mediation. In spite of my move towards social theories and anthropology of the body my organizing frame remains centred within the analytical framework of the NLS in that my focus is on multiple, social literacy practices. Theoretical influences on the social construction of the body will be discussed in more detail in Chapter Four.

The editors of the forthcoming SoUL book, Breier and Prinsloo (1995) have eloquently detailed the developments and key moves made within the NLS. I do not intend to go through them in detail, merely isolating works and theories that have proved to be illuminating and integral to my research process. My review is brief and in no way a reflection of the impact that this rich body of work has had on my own understanding of literacy as embedded in social practice.

The varied social and cultural meanings and contexts within which literacy is embedded and the deconstruction of the concept of literacy as the decontextualized ability to read and write has been the major influence on my research project and the bedrock upon which I placed my ensuing epistemological developments.

1.2 New Literacy Studies (NLS)

The NLS centres around articulating different conceptions of literacy and making them visible. These originate from research across a range of disciplines including linguistics, anthropology, psychology and education.

I pay particular attention to the works of anthropologist Brian Street. As early as 1988, Street suggested :

> That it is at the interface between socio-linguistic and anthropological theories, on the one hand, and between discourse and ethnographic method on the other, that I envisaged future research in the field of literacy studies being conducted (1993:3).

But as Prinsloo, Morphet and Miller jointly state in their paper on University -Based Literacy Theory and Practice in South Africa :

> This body of work (i.e. NLS) has not as yet had much impact on the worlds of literacy practitioners and less on policy makers in South Africa. Its impact will start to be felt, however, as it produces further tools for understanding the problems and complexities of policy and practice, as practices are brought to closer account and policy becomes concerned with the difficulties associated with success in this field. At the same time it will not be surprising if the public as opposed to the academic, understanding of literacy will continue to make exaggerated claims on behalf of literacy's social effectivity. It is likely to carry symbolic dimensions beyond its capacity given the intractable domains it is linked to : the economy, development, progress, democracy, health and happiness (1993:2).

It is against this setting that I lean towards Street's **ideological model** of literacy which is positioned against the **autonomous model** of literacy. Street's distinction between the autonomous and ideological models of literacy is pertinent to my research as well as his concept of literacy practices. Street's depiction of the autonomous model of literacy is relevant to the particular manner in which medical texts are often presented by the discourses of medicine:

> the exponents of an autonomous model of literacy conceptualise literacy in technical terms, treating it as independent of social context, an autonomous variable whose consequences for society and cognition can be derived from its intrinsic character (1993:5).

This model is based on the essay - text or school- based forms of literacy and generalises broadly from what is, in fact, a narrow, culture-specific literacy practice where mainstream alphabetic and numerical competency is understood as a culturally

neutral technology associated with an evolutionary idea of progress. In essence literacy becomes an overburdened social signifier or to use Bourdieu's term (1973) a form of "cultural capital". To quote Rockhill:

> Literacy is thus treated as though it were outside the social and political relations, ideological practices, and symbolic meaning structures in which it is embedded (Rockhill in Street, 1993:162).

Street puts forward a counter position in the form of the "ideological model" of literacy. The conception of literacy practices rather than literacy *per se*, arises out of work done within the ideological model of literacy. The ideological model of literacy rejects the notion of a great divide between oral and literate cultures as argued by Ong (1982), in favour of an oral and literate mix, dependent on social context. Street argues that he uses the term ideological because it suggests that there are always contests over the meaning and uses of literacy. Thus :

> ..the ideological model views literacy practices as inextricably linked to cultural and power relations in society and recognises the variety of cultural practices associated with reading and writing in different contexts (1993:7).

Street has been criticized for constructing a dichotomous view of literacy and of providing an approach to literacy that reduces everything to social practice leaving no substance to the concept. In reply he has argued that his perspective does not dispute the significance of technical skill or cognitive aspects of reading and writing but rather understands them as they are encapsulated within cultural wholes and within structures of power.

Thus, while Brice Heath's (1983) classic Way with Words introduced the concept of **literacy events**, as being:

> any action sequence, involving one or more persons, in which the production and \ or comprehension of print plays a role.... Literacy events have social interactional rules which regulate the type and amount of talk about what is written, and define ways in which oral language reinforces, denies, extends or sets aside the written material (Heath in Baynham, 1995:39).

Street extended the concept of **literacy event** to **literacy practices** which includes the cultural uses and meanings of reading and writing in social context.

> Literacy practices I would take as referring not only to the event itself but to the conceptions of the reading and writing process that people hold when they're engaged in the event (1993:4).

Thus the concept of **practices** forms a bridge between literacy as a linguistic phenomenon and the social context in which it is embedded and thus enables a conceptual construction that foregrounds literacy practices as social and culturally contested practices, within particular social circumstances.

> Literacy has developed and is shaped to serve social purposes in creating and exchanging meaning ; and is best understood in its context of use; literacy is ideological : like all uses of language it is not neutral, but shapes and is shaped by deeply held ideological positions, which can be either implicit or explicit ; literacy needs to be understood in terms of social power; literacy can be critical (Baynham, 1995:1).

1.3 Discourse and literacy

Gee, a socio- linguist, takes the notion of literacy one step further when he develops a definition of literacy which embeds it in Discourse(with a capital D).

> any authentic definition of literacy leads us away from reading and writing (literacy as traditionally construed) and even away from language and towards social relationships and social practices(1990:137).

The focus is therefore not on language or literacy, but rather on social practices within discourses. Literacy for him is closely allied with matters of language, culture, ideology, discourse, knowledge and power.

The term **discourse** can have a number of meanings. As it is used in linguistics it refers to the organization of language, both the written and spoken, beyond the level of the sentence, into extended stretches i.e. conversations, letters, lectures and medical interviews. Another meaning of discourse as in the works of Kress, deriving

from the works of Foucault, refers to the systematically - organized sets of statements which give expression to the meanings and values of an institution, which define and determine what can and cannot be said (Kress,1989:7). Gee (1990), influenced by Foucault's(1972) depiction of discourse as more than just language, describes discourse as socially accepted associations or rules among ways of using language, of thinking, valuing, acting, and interacting in the right places at the right time with the right objects. These associations make visible and knowable specific cultural and subcultural identities, that is who we are and what we are doing.

> Discourses are ways of being in the world, or forms of life which integrate words, acts, values, beliefs and attitudes, social identities, as well as gestures, glances, body positions, and clothes (1990;142).

Gee(*ibid*), further divides discourses into primary and secondary discourses. Primary discourses are those relating to family and social networks within the family or local community and which involve interaction with intimates. Secondary discourses on the other hand, are characterized by social institutions beyond the family i.e. church, school and work. These institutions all share the common factor that they require one to communicate with non-intimates(Gee, 1990).

Gee draws a distinction between the acquisition and learning principle. Acquisition and learning are different sources of power. Acquisition is a process of acquiring something subconsciously by practice without formal teaching. This process occurs in a natural non formal atmosphere where one "learns" through trial and error and practice, a form of apprenticeship. Learning on the other hand is a process that involves conscious knowledge gained through teaching or through certain life experiences that trigger conscious reflection. This teaching or reflection involves attaining, along with the matter being taught, some degree of meta- knowledge about the matter.

Gee's founding proposition is that literacy learning always entails the simultaneous acquisition of a discourse. Reading classes are not just about learning, they are also about acquisition of values and perspectives in a discursively constituted experience

of the world. He thus defines literacy as "mastery of, or fluent control over, secondary Discourses involving print" (1990:153).

I was influenced by Gee's distinctions between acquisition and learning and found these distinctions useful. I realized that in the context of the day hospital, literacy was often about acquiring certain discursive skills in order to participate in institutional or 'secondary discourses'. Furthermore, they frequently did not directly relate to reading and writing skills, nor the decoding of medical texts.

However, I found Gee's distinction between primary and secondary discourses problematic since primary and secondary discourses at the day hospital were not always homogenous entities. These binary distinctions are reductionist in that they did not necessarily embrace the manner :

> ...in which particular individuals speak and write from multiple and overlapping discourses. They do not therefore speak a discourse, but speak with a voice which is constructed of these multiple and overlapping identities (Kell, 1994:23).

The concepts of discursive domains of literacy practices which encapsulates the social literacies of everyday life offered a preferable framework. These discursive domains may exhibit discontinuous and contradictory literacy practices such as those evidenced within the discursive domain of the waiting room, where patients and staff were often observed to switch and utilize differing communicative codes depending on the context.

Foucault's perspective on discourse is an important influence in this study and on many NLS theorists though often not explicitly acknowledged. I found the Foucauldian concept (1972) of the term discourse helpful. In it discourse is taken beyond its linguistic meaning to mean unities of statements whose conditions of existence can be defined, and which make it possible for certain statements but not others to occur at particular times, places and institutional locations. Discourse analysis is not merely the analysis of a text or a piece of language but an analysis of the practices surrounding the texts. Analysis of these practices enables one (in my

case) to investigate and explore the construction of the hospital experience through the texts, language, narratives and voice as well as the hidden meanings behind voice and narratives. These theoretical concepts provided me with a particular lens with which to approach fieldwork.

1.4 Technology of inscription and body literacy

Kapitzke(1995), working from a poststructuralist perspective takes the position that there is no essential or "natural" way of doing reading and writing. Rather, literacy's varied meanings and forms are conceptualized as products of culture, history and discourse. She thus defines literacy as :

> .. a set of social practices using a technology of inscription (1995:8).

Technologies of inscription can be expanded to include practices and techniques of inscription. Kapitzke is referring to Foucault's technologies or specific techniques through which "truth games" are enacted. Foucault identifies four main technologies; technologies of production; of power ; of sign systems and of the self. Technologies of sign systems allow human beings to use signs, meanings and symbols (Foucault, 1988 in Kapitzke, 1995:9).

For Foucault practices of domination are tied to various techniques for textualization of the body, but not all of these practices are tied to print literacy. In fact one can say that in relation to the entire ensemble of inscribing practices in a social order, print technology accounts for a small segment in everyday life.

Kapitzke's conceptualization of literacy as technology of inscription is relevant to both my thesis and definition of literacy. I move away from using strictly print literacy defined as alphabetic literacy, to literacy's many forms of inscription. The metaphors of **technology** and **inscription** are useful for this allows one to expand on the definitions of literacy as strictly social practices around print materials to other forms of inscription, such as practices or techniques of inscription on the body. In

day hospital, I found that the move towards body literacy enabled me to uncover hidden literacy practices,(those not strictly alphabetic) and to thereby understand dissonances that had appeared incomprehensible before.

Foucault's(1979) notions of bodily inscriptions or technologies of writing move away from viewing literacy as a natural biological or essentialist phenomenon. He examines the way in which power is inscribed on bodies through processes and mechanisms of surveillance, supervision and self- regulation in institutions such as prisons, schools and hospitals. Lives are described and fixed in writing as part of the textualizing process of the institution. The apparatus of writing constituted the individual as a describable, analyzable object ; a case to be judged, measured, and compared with others (Foucault, 1979:191). Thus in the day hospital the body through the action of medical literacies becomes a social text capable of being read and interpreted. Through the medical "gaze" the body is read as an assemblage of symptoms and diseases. The medical gaze is in turn attached to practices of writing, recording and encoding body symptoms and signs. Medical literacy or inscription is secret or specialized knowledge particular to the medical domain. These dominant forms of literacy are themselves answered by what I refer to below as social or local literacies.

1.5 Social literacies and local literacies

In contradistinction to standardized reading, writing and numeracy competencies of mainstream literacy, social literacy is defined as literacy practices embedded in social context. Social literacies emerge into visibility when certain modes of encoding and decoding achieve dominant political and organizing power over peoples' lives and begin to colonize their everyday life spaces. What I call social literacy arises in an attempt to decode dominant alphabetic literacy; to decode the world that is reorganized or constructed by dominant literacy and mediate or resist dominant literacy in terms of pre-existing cultural values or beliefs. Thus socially embedded

literacies emerge in the gap created by the discontinuities between dominant and non dominant knowledge systems.[2]

I argue for a context specific understanding of literacy. Thus while accepting Street's(1994) use of the terms "local and vernacular literacies", I broaden the concept to include social and \or local literacies as it relates to the particular social experiences and literacy practices encountered in the medical domain. I avoid the use of the term 'indigenous' literacy, local literacies cannot necessarily be reduced to one single origin but are diverse and varied consisting of a cultural hybrid.

Medical literacy and technology as part of mainstream alphabetic literacy, base their legitimacy and authority on being socially decontextualized and do not take into account the everyday life practices and the existing resources of patients. Street (1994) in the context of adult literacy programmes, talks about the need to recognize local literacy practices in their complex and varied forms. However, in the context of the day hospital, I argue that it is not only a question of acknowledging different literacy variations but that these variations can be viewed as a form of resistance and contestation to dominant medical literacies or expert knowledge systems. In my research the resistance or tension that arises between local literacies and dominant medical literacies and technologies does not necessarily take the form of opposing Western medicine *per se*, rather it entails a complex negotiated process whereby dominant medical literacies are frequently re-appropriated and re-transcribed to suit local needs. In this process, medical literacies take on meaning within the context of patients' everyday life worlds. The latter process does not necessarily take the form of resistance but can be the manner in which patients manage their relationships to and understandings of the medical system. Social literacies can therefore include the manner in which patients respond to expert knowledge systems from within their own social environment and how it is recontextualized from one form of literacy to another.

[2] I am influenced by Feldman's(1995b) depictions of social literacies.

1.6 Literacy in multicultural and multilingual settings.

To research the significance of literacy practices in terms of social meaning and location within social context required articulation of an explanatory framework that was adequate to the task of giving meaning to the diversity, heterogeneity and complexity of social practices encountered. This opened up the space for considering the existence of multiple literacies, domains and genres of literacy. Baynham(1995) and Barton(1991) have explored the notion of multiple literacies in multicultural and multilingual environments which I would argue is the reality of urban areas in South Africa. Multiple literacies consist of a mix of dominant, non dominant, local and community literacies as opposed to institutional or school- based literacies, vernacular as opposed to essay- text or academic literacies.

Baynham(1993), introduces the concept of literacy mediators or cultural brokers in the multilingual and multicultural setting of the Moroccan community in West London. Baynham defines mediators of literacy as people who engage with literacy tasks on behalf of others. An important aspect of literacy mediation is that it involves code- switching (between languages) and mode- switching (between oral, written, visual and other sign systems).

Fingeret (1983), in her study of "illiterate" adults in urban America, has made an important contribution towards deconstructing the deficit view of illiterate adults by exploring the intricate social networks of exchange and reciprocity between those who have the necessary literacy skills and those who do not. Fingeret's skills-orientated understanding of literacy networks tends to depict all literacy mediation as synonymous with networks of reciprocal exchange associations. Relations of power and the role of agency in literacy mediation are underplayed. Following Malan (1995), I too caution against viewing all forms of literacy mediation as constituting networks of reciprocal exchange. In certain contexts, for example institutional settings, literacy mediation can serve to underwrite subjects to the normalizing gaze of institutional power and social control, whereby literacy mediators play an important socializing role between subjects and their induction into the hierarchical structures of the institution. Thus based on my understanding and experience of

literacy mediation in the day hospital environment, I argue for a differentiated understanding of literacy mediation which takes into account that the agency of literacy mediators is invested with varying degrees of social power.

This review of academic literature describes the major influences towards my developing understanding of literacy and my subsequent theoretical moves. My initial understanding was not sufficiently complex to do justice to the dynamics in the field, especially if I was to take into account patients' own subjective experiences of the medical literacies. This ultimately brought me to explore the notion of body literacy.

The deconstruction of literacy which the NLS provides opens up the space to explore differing "readings" of the term literacy. This reconceptualization of literacy as a culturally contested process involving relations of acquisition, mediation and cultural brokering was useful. Yet in spite of this, the conceptual signposting remained at the level of print literacy. In order to address the literacy practices of patients at the hospital I needed to explore other forms of literacy which went beyond the boundaries of print literacy. How were the patients bodies being read by the medical discourse and by themselves? I decided to look at the concept of body literacy as one further arena of literacy, conceptualizing the body as a text. Where:

> the body is viewed as a writing surface, a blank page, upon which social messages, meanings and values are inscribed (Kapitzke, 1995: 16).

The notion that the body is a text upon which cultural fictions and narratives map meanings for self and other is theoretically supported by the works of Foucault(1979) and Kapitzke(1995) and is explored further in Chapter Four.

1.7 Specific context of research site

I now focus on the specific research site and the context in which literacy practices are located.

Hout Bay is situated off the Atlantic coast on the Southern Cape Peninsula approximately 20 kilometers from the centre of Cape Town. The Day Hospital is an out patient clinic which is situated in the "Coloured" section of the Hout Bay Harbour area. The harbour community locally referred to as the 'fishing village' is a residential Coloured area, an enclave situated within the greater Hout Bay area.[3] The Day Hospital is open from Monday to Friday from 8 a.m. to 4 p.m. It is closed on Saturdays and Sundays and on public holidays. Most patients are treated for common ailments such as flu, colds, gastro- enteritis and more chronic illnesses such as diabetes, asthma, hypertension and epilepsy. All acute medical cases are referred to the larger nearby hospitals.

There were a number of reasons for choosing this particular research site. One of these was my previous experience as a nurse. I had worked for eight years as a professional nurse in Northern California in a large teaching hospital with a multicultural and multilingual patient and staff population. The difficulties and discontinuities that often existed between staff and patients, in terms of cultural values and language barriers were frustrating and made the delivery of adequate health care problematic. I was often to reflect back on my experiences there and on how in-place cultural beliefs and practices were seldom acknowledged.

My knowledge of the daily functioning of a hospital helped me in my choice of a particular site for field work. Entry into this specific field site was facilitated through personal contacts with a staff member. I decided to choose a field site that was accessible not only in terms of geography, but one in which I foresaw no language barriers, since I am fairly fluent in Afrikaans and one in which patient numbers and level of illness would enable a more detailed and in-depth study.

Safety as a white female researcher was another personal issue that I had to confront. Mobility into and out of the area was made easy because of the field site's particular historical and social location situated on the periphery of white suburbia. A circular

[3] Refer to Chapter Two and Three for a more detailed description of 'racially defined' spatial constructs created during the apartheid regime.

tarred road provides access to the infrastructure in the area and is linked to the main access roads leading to the harbour, the city and other areas of the Cape Peninsula.

My first few visits were informal, I merely visited and interacted with the professional staff. This was an important step in the research process as I foresaw potential problems in my dual role as being identified as part of the medical domain whereas my motivation and rationale was as a researcher. I did not want to be seen as judging nor surveilling their nursing practices. Issues of professional integrity, identity and performance needed to be clarified and confronted. The subtexts of race, gender, class and professional hierarchical structuring needed to be addressed, since nurses were with the exception of one, all "Coloured" and female. Racial classification and hierarchies under the apartheid regime had provided inequitable and separate nursing training and education and I might have been perceived as having obtained superior "white" education and nursing experience. By acknowledging and discussing these issues and underlying power relations, I hoped to put aside potentially discordant feelings between us.

1.8 Research methodology

The research method chosen in this thesis is primarily **ethnographic** in nature. Although my background as a nurse has had an important impact on the manner in which I have constructed the research object, the ethnographic approach with its intense concentration on the place itself, allowed me to distance myself from the medical discourses in which aspects of my own identity had been constructed. Self reflexivity, an integral component of ethnographic method, allowed me, despite my involvement as a nurse, to distance myself from the research object as well as to consider my relationship to it.

While I had hoped to provide, through interpretation of the data, new theoretical insights and understandings of the research object, I was initially overwhelmed by the data. Through re- reading and re-analyzing my field notes and interviews I began to realize that what was required was to let the data and subjects speak for themselves, recognizing that my informants were often eloquent theorists themselves. I frequently

had to hear what they were saying in non- discursive forms, in the silence, laughter, body gestures, facial expressions and their actions within the clinic.

Within the discipline of anthropology, ethnography has been defined and practiced since 1900. The main focus of ethnography is a study of people's self understanding of their life worlds, their everyday life practices and belief systems. Feldman has asserted that the primary means for conducting ethnographic research and inquiry :

> is not solely observational and journalistic style description, but rather the conduct of intense, long standing dialogues between ethnographer and informants, in which the most important descriptions are those generated by actors from within the milieu being researched, and not solely by the researcher who is external to it (1994:20).

Ethnography is defined in numerous ways by various ethnographers but a common theme is the way in which the practice places researchers in the midst of what they study. In this process :

> Ethnography frequently involves the abandonment of pre-conceptions and pre-field research models on the part of the investigator, who has to define his/her role in the context of profound difference (Feldman, 1994:20).

Similarly, Geertz, describes ethnography as "thick description":

> What the ethnographer is in fact faced with...is the multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another, which are at once strange, irregular and inexplicit and which he(sic) must contrive somehow first to grasp and then to render(1973: 10).

Thus the ethnographic method afforded me the possibilities of uncovering the complex and multiple layers of social reality. Ethnographic research methods are not the detailed collection of descriptions as they occur, but involve intense engagement in the field, where one is constantly shifting and reassessing one's position. In confronting the field site, I found Foucault's (1972) metaphor of "archaeology of knowledge" useful. As one discovers ideas, one uncovers precursors to them in the shifting and deeper layers and strata of an archaeological site.

1.9 My relation to the research object : personal rite of passage.

The concept of self reflexivity, which I argue is integral to an ethnographic study, relates to my own experience in the field. It becomes necessary to make explicit my personal background for as Gadamer (1975) proposes, interpreters who are attempting to grasp the meaning of an action or phenomenon, have their own understandings shaped by the fact that they themselves are members of a particular culture at a particular historical moment. Interpretation therefore requires that the interpreter must become "hermeneutically aware" of his or her own historicity or pre-understanding.

In anthropology, postmodernism and post-structuralism have put the "critique of objectivity and scrutiny of ethnographic authority onto the disciplinary agenda" (Bell:1993 in, Breier :1994). This has led to the emergence of reflexivity as an aspect of ethnographic method. Clifford traces the history of self reflexivity in ethnography back to the publication of Malinowski's diaries and the enormous impact that these self- revelations had on the field of anthropology.

> The publication of Malinowski's Mailu and Trobriand diaries (1967) publicly upset the applecart. A subgenre of ethnographic writings emerged, the "self reflexive fieldwork account". Ranging from sophisticated and naive, confessional and analytic, these accounts provided an important forum for the discussion of a wide range of issues epistemological, existential and political (1986:14).

Reflexivity is often associated with self examination and critique, and the acknowledgment of subjective interpretations and positioning in relation to which the ethnographer provides relevant personal information. This has become increasingly important in my own research process as I have found myself moving between different positions, that of the ethnographer and that of a nurse with residual medical preconceptions and assumptions.

There has been much debate about the objective and "authorial voice" in anthropology and more specifically ethnography. Geertz, in exploring the problems

associated with the construction of ethnographic texts and the manner in which the anthropologist as author is positioned within texts, provides some useful insights into the 'authorial presence' or 'authorial voice' :

> Within anthropology it is hard to deny the fact that some individuals... set the terms of discourse in which others thereafter move. The distinction between authors and writers or in Foucault's version, founders of discursivity and producers of particular texts is not as such one of intrinsic value..... It is now hard to tell who the authors are and who will discourse in whose discursivity (Geertz, 1988:19).

Similarly, Barthes in the " Death of an Author" states that a text cannot be seen as the pure medium of an authorial intention. Rather, a text is a multidimensional space in which a variety of writings none of them original blend and clash (Storey, 1993:85).

I was faced with the daunting prospect. How was I to present and interpret this material as objectively as possible ? Through my readings around ethnography and the authorial presence I realized that this was a contested issue. The frequent use of the first person singular made me uncomfortable and I was conscious that it might appear that I was using the academic forum as a place for self searching and cautioned against using the moment of self reflexivity as a form of solipsistic practice. I was not the object of study yet as the research progressed I increasingly began to realize that my positioning was integral to the research process. As Bakhtin(1968) has shown in his notions of carnival, many voices clamor for expression in a discursively constructed space. In traditional ethnographies, polyvocality was restrained and organized, so as to confer to one voice a pervasive authorial function and to others the role of informants or "sources" to be quoted or paraphrased. The new tendency to name and quote informants more fully and to introduce personal elements into the text is altering ethnography's discursive strategy and mode of authority. Clifford asserts that:

> ethnography is now hybrid textual activity, it traverses genres and disciplines (1986:26).

The acknowledgment of cultural hybridity; diverse and multiple voices and genres in the field is perhaps the most challenging aspect of ethnographic fieldwork, having a causal relationship to the manner in which data is gathered, interpreted and analyzed. At times I began to lose my own discourse, and the discourse or communicative forms of my informants and had to re-evaluate the complex interplay of voices, fragments of speech and narratives that I encountered.

Bell, Caplan and Karim(1993) explore the role of gender in anthropology and how it impacts on ethnography and fieldwork. They note that feminist or gender issues have been largely ignored by the anthropological academy. Anthropologists, more specifically male anthropologists, despite their critique of objectivity and ethnographic authority continue to ignore or marginalize women's voices.

> Those anthropologists who have taken the postmodern turn into textual analyses and plurivocality are forthright in their attention to 'native' as 'other', but tracing a genealogy entirely through males.... are silent on the matter of women as 'other'(Bell, Caplan & Karim,1993:3).

Furthermore, despite the centrality of self- reflexivity within the discipline, reflexivity has not necessarily included an awareness of gender, particularly as it relates to fieldwork experiences.

Social origins pertaining to gender, race and professional position played a decisive role in the way that data was obtained. Different informants related to me differently, depending on how I was identified within their social world. Professionals related to me as professional peer and as "Sister". Patients also called me "Sister". Both are framed within medical and sexist discourse. Other patients and visitors related to me as a 'white married woman' addressing me as "Mrs." or " *Mevrou*" and sometimes Miss. One woman asked me :

> What must I call you Miss, must I call you Miss or Sister?

I found that I was often assigned a particular discursive position by staff and patients alike. The above statement reflects the multiple positions and roles assigned to me,

as a white women, a researcher and as a professional nurse. It was not merely a question of identifying and acknowledging these subtexts of race, gender, class or professional status, but affected the manner in which I constructed my own multiple and shifting identities within this community. Thus each of these roles offered constraints and possibilities in terms of the research process and each needed to be examined. I found it necessary to consider the manner in which the person interviewed or spoken to, (however informally), had positioned me and to take cognizance of this when collecting and interpreting my data.

I decided to accept and utilize the discursive positions ascribed to me by professional staff and patients, feeling that it could provide further insight into the complex web of social relationships within the medical domain. On the odd occasion I did respond to medical initiatives and did "help out", offering medical expertise in situations that were appropriate, mainly on the level of medical advice. Thus I switched roles between research and intervention, what Feldman(1995a) has referred to as the "doubled optic of research and intervention".

I argue that my position in the field as a white, middle class, female, graduate student, researching and observing patients in an institution, is in itself an intervention. One is never an impartial observer, one's mere presence is a form of intervention. Thus I would argue that self reflexivity is a crucial component of ethnographic practice, because cultural conceptions always inform perception in a multicultural, multiracial and multilingual environment such as the clinic. Any scholarly enquiry must therefore be culturally self reflexive.

A concern that I had anticipated at the outset of my research and in my initial research proposal was how to confront my own medical gaze. I started out by making a conscious decision to subvert my medical gaze, but soon realized that it had afforded me an entrance which might have otherwise not been possible. It was often my prior medical experience that facilitated and made the initiation process into the field site that much easier. I had been accepted into the field site by both patients and staff, not because of my position as a researcher but as a nurse.

Repeated utterances from professional staff illustrates this point:

> You understand us, and what this clinic is all about. Make yourself at home and just ask if you need any help or have any questions.

It was through the medical gaze and their perception of my position within the medical domain, that many of the women[4] found a safe and contained space beyond their daily hardships, and a symbolic sealing of the social contradictions of their lives beyond the clinic environment. This will be discussed further in Chapter Four.

1.10 Data collection

One of the effects of doing ethnographic research is that the social world as experienced and lived is encountered in unpredictable and diverse ways.
I made use of informal interviews, participant observation and the recording of social narratives to develop an account of literacy practices.
I found that identifying key events (see Geertz on Balinese cockfight)[5] enabled me to isolate certain phenomenon and medical scenarios that I wanted to explore further and helped provide some order to the data. These consisted of observation and interviews centred around the Family Planning and Baby clinics. I chose these informants as they visited the clinic frequently and I was thus able to establish some form of continuity. I undertook ten visits over a period of four months, in which I interviewed patients in the waiting room, women attending the Family Planning and Baby clinic, the Nursing Sisters and the receptionist(clerk). Although the women attending the Family Planning and Baby clinic formed the core of my research, I also interviewed people that approached me, or who I had seen on the odd occasion. Schoolchildren in the outside space, and a ten year old boy who greeted me at my car each time I visited were also interviewed. I frequently moved to the outside space, where patients sat in the sun, smoked cigarettes or socialized. I sat on the steps outside and chatted to patients, holding discussions around their medications or Family Planning appointments. A visit to the harbour, local library, museum, shops and surrounding residential area was undertaken.

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[4] Most notably, the women interviewed in the Family Planning and Baby clinics.
[5] Geertz, 1973.

All patients interviewed were from the Hout Bay harbour area, within a 0.5 km radius of the hospital. They were part of the "community" with the exception of two Xhosa-speaking patients from Mandela Park squatter camp and two women from nearby Kronendal farm. Gender and racial breakdown reveals predominantly female "Coloured" informants though I did interview one female Xhosa woman who spoke in English. My interviews were conducted in English or Afrikaans depending on which language the informant preferred. We often switched between English and Afrikaans and the local vernacular resulting in a mix of local dialect and English.

I attempted to position myself in the field in a mid- liminal space, between the events as I saw them unfolding and what I was experiencing through my various discursive positioning. By confronting my multiple positions, that of a researcher, that of a white woman, and that of a nurse all with their corresponding theoretical constructs I hoped to faithfully reconstruct what was occurring in the field. However, I began to realize that ethnographic knowledge does not remain static, but gets transformed, reorganized and reconstructed both in the return to the academic world of writing up the thesis, as it does in the field.

I tried to address and answer my initial research questions by exploring the interface between the discourses of the medical domain, represented by professional staff and their corresponding literacy practices, and the discourses and literacy practices of the community as represented by patients and their extended social networks.
I made use of unstructured interviews and participant observation to develop an account of not only literacy practices, but the reconfiguration and reformulation of medical and social discourses that I sensed at this earlier stage of my research process. Going back to my very first visit I record in my field notes:

> The general feel and from my medical gaze, is that this does not particularly feel like a hospital. It is difficult to tell how intimidating the environment is to the patients. I leave feeling that a multiplex intersection of community and literacy networks is taking place(Field notes,15/8/95).

These literacy networks were expanded to include local literacies and somatic literacies. The latter are literacy practices as embedded in discourse pertaining to the body and its associated language. These concepts only became clearer as my work progressed, and I began to uncover the different strata of human interaction and experience.

Participant observation proved useful for numerous reasons. The noise level, coupled with the continual movements of patients in and out of different spaces made interviewing difficult. It was easier to initially observe and engage in conversations at a later stage. Patients were often not physically able to engage in lengthy conversations making observation an easier alternative.

The field work of the study was conducted from August to December, 1995 with two "orientation" visits in June, 1995. I began by visiting the day hospital on an informal basis introducing myself to staff, making preliminary arrangements and familiarizing myself with the environment. I was unable to return to the field site until August, 1995. In the interim I read extensively orienting myself to the basic tenets of ethnographic fieldwork.

In my employment of informal interviews of patients I ran into problems. It was difficult to interview in the midst of a noisy waiting room, yet I felt by moving out of the immediate environment into a large empty room (the only available place) would create a false and formal atmosphere. I transcribed my own interviews. The process was made easier in that all interviews were conducted in English or Afrikaans, according to informants choice and more often than not informants switched between English and Afrikaans with sprinklings of expressions and idioms particular to the vernacular of the Western Cape region. In transcribing interviews, the richness of the local vernacular is often lost as it is frequently context specific. For example, the term "*skollies*" is difficult to translate as it signifies a criminal element located in the context of gangs, prevalent on the wastelands of the Cape Flats (30 kilometers away). However, the term and it's connotations have been extended into this particular community.

I made careful note of non- verbal cues such as dress, body language and gestures, and the pauses, silences and laughter, paying particular attention to social conversation between informants, who was included and who was excluded. This was an attempt to uncover the silent unspoken rules of discourse.

Data was recorded in the form of field notes and taped interviews. At times I worked from memory, recording all observations and conversations immediately after an informal interview. I never wrote nor recorded any conversations during informal interviews with professional staff. We had established a relationship in which there existed a free flow of ideas and often spoke about our own professional experiences. Recording or writing during these dialogues would have disrupted the interchange of ideas between us. Another reason for not recording conversations during interviews, was the frequent interruptions. The pace was fast, and patients often needed to be attended to swiftly. The only "free time" that staff had was tea breaks; a ritual in which I was always included. The tea room was a place in which I often gained information about the daily happenings in the hospital.

Communication and dialogue with the doctors was limited. I had decided at the outset, due to the time constraints and the vast material to be covered, that interviews would be limited to the nursing staff as representatives of the medical domain. The decision to focus and restrict my interviews to the nursing staff centres around the primary role that they play in the functioning of the day hospital. The Community and Regional Health Services sector of the hospital is run entirely by Community Nursing Sisters. The most intense and frequent interactions are between the nursing staff and patients. Patients spend only a brief period in the doctor's consulting rooms. As previously mentioned, my medical background further facilitated and influenced my decision to focus on the nursing staff as representatives of the medical institution. I realized that I had to present wherever possible, a non-judgmental and non-evaluative stance towards the nursing staff 's professional practice. I set out to ensure that I was not viewed as judging nor surveilling their practices or working conditions which were often perceived as different from my own experiences.

On one occasion I was told that it was not possible to sit inside the Family Planning consulting room as it was "too cramped", yet I had been able to be an observer at the Baby clinic where space was even more compromised. I soon learnt in which areas I might be imposing.

A further instance in which I had to be extremely tactful, was when nurses attempted to help me in "choosing" informants by stating:

> We have nice patients for you. Do you want me to find you patients who cannot read or write as most of our patients are literate.

Paternalistic images of patients are created through phrases such as ; "nice patients"; "my favorite patient" and "our", or "my patient" and I had to subsequently explain that I was not necessarily concerned with a particular patient profile.

In hindsight, my interviews with patients proved less problematic than I had anticipated. Establishing a relationship in which I had made explicit my position as both a researcher and a nurse enabled me to move between differing positions as the situation allowed and provide medical advice if requested. In one instance I explained to a patient how to take her medications and what side effects to anticipate.

My capacity to conduct satisfactory research at the day hospital was hampered by certain factors. Firstly, the time available for research was too short as the dissertation is a mini thesis. At times I felt frustrated and curtailed in my research endeavors and felt that I had to of necessity, exclude or ignore, important avenues of further exploration. Secondly, for reasons of time constraints and safety I was unable to go on home visits. Within the SA context, it is almost impossible to avoid experiences of race and racial classification established under apartheid. These experiences inevitably impact on the research process, affecting the manner in which the researcher is perceived by the community into which one enters. Thus access was affected by racial and gender considerations. I was repeatedly advised by patients and staff that it was inadvisable to go out alone into the community. The area in which the majority of the informants resided was no longer considered safe. My safety as a

lone, white female researcher was a significant factor to be considered. I was informed of the increasing crime rate and the activities of gangs in the neighbourhood. This can be viewed as a significant gap in my fieldwork, but wherever possible I tried to elicit home and family conditions from both informants and staff.

Closure and having to subsequently accept that there is a point where closure needs to occur, was the most difficult component of the research process.
As the research progressed it became evident that I needed to gain a socio-economic background and history of the political economy of the area to understand where people were coming from and where they were going to.

I have decided to change the names of informants and staff. This is to protect and maintain patient and staff confidentiality. Wherever possible, I have tried to find names that capture the quality of the informants' real names. The two nursing Sisters that I had the most contact with are called Sister A and G.

1.11 Analysis of data

In this section I construct an understanding of what goes into analysis. This involves integrating theoretical texts with empirical work. The translation and merging of theoretical concepts with raw data is perhaps the most challenging aspect of any research process. In the writing up of the research and in the conceptual ordering that this process requires I have tried to make sense of this heterogeneity and cultural hybridity by utilizing analytical tools which would be consistent with the ethnographic research method. I work closely with the notions of narratives and voice through informal and unstructured interviews, as I attempt to uncover the layers of meaning in the lives of informants as well as their uses of literacy. The dialogical relationship is perhaps one of the most useful and illuminating ways of attempting to understand the life world of the people that one is studying. Shared meanings and codes are often expressed in dialogue and in performed actions.

I have found the concepts of incompleteness and subjectivity desirable and the transparency with which I have attempted to work has afforded me the possibility of recognizing not only the pitfalls of academic texts but that epistemological discovery is an ongoing and often contested process. There have been numerous instances throughout the research process in which I have had to reflect on my position in the field. This has not been an easy journey yet by frequently confronting and reconceptualising diverse discursive positions in the field, I was able to discover new ways of looking at the research object. Throughout my research I have been drawn by the idea of "messy texts" which Marcus supports in his leaning towards "the deconstructive bent, modernist ethnography counts on not being first, on not discovering. It remakes, represents other representations" (1993:27, in Kell, 1994:17).

1.12 Summary and chapter outline.

This opening chapter provides an introduction to the specific research questions with which I entered the field site and the major perspectives and influences that have been drawn on. I offer my own analysis of how one might best conceptualize the relationship between literacy practices and the social world of the informants in the field site. I note that the NLS has not only influenced the methodological and theoretical approach of this study but has contributed to my epistemological and consequent theoretical move from print literacy towards body literacy or the body as text. I thus extend the focus or field to include literacy as embodied in text and discourse as it intersects with the social constructions of space and the body. I also work with Street's (1993) and Baynham's (1995) concepts of literacy practices which firstly emphasize the social nature of literacy, and secondly, the multiple and often culturally contested and ideological nature of literacy practices.

This study draws on the field of anthropology in numerous ways, firstly in following an ethnographic approach to data collection and secondly, its concern with the position of the researcher within the research process, that is the process of self reflexivity.

In Chapter Two, I explore the relationships between texts and literacy practices in the place. I argue that texts are always located within particular social contexts and that understanding literacy involves studying both the texts and the practices surrounding the texts. I provide a narrative description of the Hout Bay Day Hospital and various texts and associated literacy practices encountered within four discursive domains of literacy.

Having provided a description of the place, the focus now moves towards an examination of literacy practices within socially constructed space. In this chapter, Chapter Three, I expand the notion of space and place as previously discussed in Chapter Two. At this juncture I provide a brief history and socio-political narrative of the area within which the day hospital is located. I work from the premise that space is not merely an objective material reality nor geographical place, but is socially constructed.

In Chapter Four I make an epistemological move towards body or somatic literacy. I extend the exploration of 'ways of seeing' literacy to include practices or techniques of inscription on the human body. The central focus of this chapter is on the women attending the Family Planning clinic, more specifically their cultural constructions around contraception.

In Chapter Five, the conclusion, I summarize the findings of the previous chapters and return to the theoretical concepts utilized in uncovering the varied ways of 'seeing literacy'. I tentatively offer some suggestions for future debate and research and the possible value of this research for health care initiatives.

CHAPTER 2

NARRATIVE DESCRIPTION OF LITERACY PRACTICES AND TEXTS WITHIN THE DAY HOSPITAL

2.1 Introduction

In this chapter I explore the relationship between texts and literacy practices within the Hout Bay Day Hospital. I argue that texts are always located within particular social contexts and that understanding literacy involves studying both the texts and the practices surrounding the texts. It is not my intention to provide an inventory of the numerous texts encountered in the clinic, but rather to provide a narrative of texts and literacy practices and the manner in which they are discursively constructed within the various domains of the clinic. It became necessary to extract and analyze certain texts and literacy practices in order that their embeddedness in the institution and fabric of the social life of the patients could be explored. In a social literacy approach, texts and literacy practices are inextricably intertwined. In my findings they were however not always linked. There were numerous texts around, but they were often isolated and removed from practice. They literally formed the "walls of the institution" but little else.

Baynham and Street's definitions of literacy practices emphasize the ideological and culturally contested nature of literacy practices :

> Investigating literacy as practice is not just what people do with literacy, but also what they make of what they do, the values they place on it, and the ideologies that surround it (Baynham, 1995 :1).

Thus even though interactions with most texts were not visible, their presence and the manner in which they were often displayed represents an implicit ideological position.

I propose to examine the ideologies and discursive formations around these texts by posing the following questions:

- What do the texts represent in this space?
- How are they received by patients?
- How are they understood by staff?

The fact that there is very little interaction with texts in the sense that there is no visible reading and writing opens up the space for variations of literacy practices. I argue that patients use certain genres of communication which are not standardized medical discourse but rather their own local vernacular practices.

In providing this overview I intend to work with multiple voices weaving a narrative. This includes the voices of people initially encountered in the day hospital. In the first part of the chapter the voice is my own, my field notes about entering the day hospital, about being constituted as a researcher and about meeting and engaging with informants. I use this voice to describe elements of the research process. My descriptions of texts and literacy practices are fashioned around what I initially saw, read and experienced from my own position as a researcher and from the voices of the informants and how they constructed what they saw and experienced. One of the main goals in using the narrative voice is to present a detailed description of the hospital environment, the patients, the staff and their interaction with each other.

In popular discourse the day hospital refers to the people who run the hospital, those who attend it, and to the building that symbolizes its presence. The day hospital positions the subject, whether patient or staff, and locates them in a socially constructed space. [1]

[1] I use the term day hospital and clinic interchangeably as both terms are used interchangeably by staff, as well as in the official discourse of the CPA (Cape Provincial Administration) and Regional Health Services.

2.2 DESCRIPTION OF SPACE

2.2.1 Entering the institution

I recall my first visit to the day hospital. I encounter difficulty in finding the place despite the fact that I have been given clear directions. I drive up and down the road several times only to discover that I am actually outside the hospital. The Day Hospital is situated on the ascent of the hill in close proximity to the Hout Bay harbour. In contrast to the nearby mosque, library and school, it is a small unimposing single storied building. I scarcely notice the small printed sign on the entrance stating **C.P.A. DAY HOSPITAL**. The genre of architecture blends in well with the surrounding residential area. There is no signpost indicating the location of the day hospital, yet there is a signpost for the library and Apostolic church. I ask why there is no signposting and what this might mean. Why the Apostolic church and library are signposted whilst the day hospital is not? It appears as if through its lack of official inscription the day hospital has been relegated to the margins of the community. I later ask a patient and staff member if they are aware of any sign giving directions to the hospital and whether I may have overlooked it.
Their responses are :

Patient: Well, we all know where it is.
Sr.A: Most patients know where we are and most patients have no cars.

Both these statements would endorse the view that the hospital requires no signposting. Likewise, it would appear that the City Planners and Traffic Department have also decided that it needs no identification through signage but for different reasons. It would appear that as the day hospital has become part of the community's social world and everyday experience it requires no signage. I focus on the lack of outside signage as I feel it has symbolic significance. There is a causal connection between the community's location on the social and economic margins of the greater Hout Bay community and the clinic as health care provider. Both are situated on the socio-economic margins in terms of geographical location and in terms of the organization and hierarchical structuring of the Public Health care system.

Similarities can be drawn between Rockhill's descriptions of the inferior health care provision experienced by immigrant Latino communities in Los Angeles and the patients attending the Hout Bay clinic.

> They (Latino immigrants) form the ghetto of the health care system, standing in long lines, waiting for hours at overcrowded clinics where they can only receive only the most cursory medical attention, for, if screened into hospitals, they cannot afford them (1982:15).

The minibus taxi rank is situated further down the hill. There are people milling about and a few taxis are parked at the bus stop. Scholars are walking up and down the hill, a phenomenon to which I was to become accustomed. No matter what the time of day there were schoolchildren on the streets and I was often to meet them at the hospital. Furthermore there is always a steady flow of men, women, children and dogs walking up and down the hill. The neighbourhood assumes a rhythm of its own. Some men are sitting on the grassy pavements talking and some are standing in the street or in the small parking lot and driveway of the hospital talking animatedly and smoking. Women are talking over fences and hanging up washing. Children are riding bicycles or skate boarding up and down the street. One's senses are bombarded by the smells and sounds of the nearby fish factories, the hooting of taxis as they speed up and down the hill, dogs barking, children crying and the sound at noon of the muezzin calling the faithful to prayer. These sounds often filter through into the day hospital. The muezzin's noontime call to prayer reverberates throughout the entire hospital, all other sounds are for a brief period, drowned out.

2.2.2 Writing in the informal space.

It is interesting to note the difference between the writing on the walls outside the hospital and the writing on the walls inside. There is graffiti on the outside wall of the hospital, the letters are distinct and well formed.

The graffiti reads:

- VIVA ANC
- VIVA SACP
- VIVA COSATU
- VIVA MK
- VOTE JUSTICE
- VOTE PEACE

The graffiti is the first literacy practice encountered. It is evident here that the authors have taken an explicit ideological position. The popular discourse of the SA liberation struggle is reflected in the words; VIVA, JUSTICE and PEACE. The political messages are clear in their support of the ANC, Communist Party and the trade union, COSATU. The message is a political anomaly in that the text is in English yet the lingua franca of this community is Afrikaans. I gather that the political messages do not necessarily reflect the political sentiments or support base of this area. I asked Maggie, a patient, if she knows anything about the graffiti.

Maggie: *No Miss, jy weet dis mos daai skollies.*
No Miss, you know, it is those thugs.[2]

Sister A informs me that the graffiti was inscribed prior to the April 1994 elections.

2.2.3 Entrance and exit

The hospital is set back from the road and entry is made difficult by a narrow entrance and a winding driveway that is only able to accommodate one motor vehicle at a time. I am directed by a hospital worker into the driveway and negotiate my way around patients, children, dogs and bicycles. The manoeuvring of cars in and out of the small parking area which doubles up as a back yard and general meeting area is

[2] Translations into English were often difficult and wherever possible I have attempted to translate as accurately as possible without losing the richness of the local vernacular. Meanings are often lost in translation and in this particular instance, the term *skollie* has varied meanings, depending on context. In certain situations it refers to hooligans or thugs and in others to gangsters.

part of the daily routine of the hospital. The hospital cleaner has assumed the role of informing staff and visitors when to move their cars in order to allow other cars to enter. An ambulance with the assistance of a few bystanders is trying to manoeuvre its way in. This is a slow and arduous operation.

One enters the clinic from two possible entrances, there is no sign demarcating the entrance or the exit. The door is permanently open to the general public and is only locked at the end of the day with the closing of the clinic. The entrance and exit assume symbolic meaning because in numerous ways they embody the dynamics of the social practices present in the clinic.

I now consider the symbolic meaning of the entrance and exit to the institution. Entrances and exits manifest the divisions between inside and outside, between domestic and foreign and negative and positive social constructions of space. Van Gennep (1960), in the now classic **Rites of Passage,** identifies the passage from one social position to another as a territorial passage such as the entrance into a village or house, the movement from one room to another or the crossing of a street. This identification explains why the passage from one group to another is often ritually expressed by passage under a portal or by the opening of a door. In the case of an institution such as a school or hospital, the door is the boundary between the foreign and domestic worlds. In the case of a temple or church, between the sacred and the profane. Crossing the threshold, as for example in marriage, is symbolized by a door which separates one world from another world. Therefore, to cross the threshold is to unite oneself with the new world. In the social world of the clinic, the door or entrance is the boundary between two differing worlds; the world of the medical institution and the social world of the patient. Therefore to cross the boundary is to be initiated into a new and often unfamiliar world. The patients entering the clinic are in this view moving from one social position to another. They move from the local, from their homes and the community, into the unfamiliar, the medical domain. Yet in this instance the territorial passage is not a fixed structure. The boundaries represented by entrance and exit are not clearly demarcated, nor are they permanent entities but loosely constructed. The physical and structuring devices

of the entrances and exit (doors, locks and signs) have been informalized by both staff and patients in their often free movement entering and exiting the clinic and in their refashioning of the practice of queues and of paying outstanding accounts. However, there are certain procedures and stages which are part of the induction process that are rigidly adhered to. Patients, through their manner of entry or exit into the clinic are placed in the anomalous position of being both in and out of the institution.

The procedure at the reception desk which requires patients to register and fill in forms and pay R8, the queue structure and the signage in the reception and other clinic areas, is all part of the induction process into the medical institution. One cannot be seen by the doctor without following these formal procedures. Yet as I argue throughout the thesis, the formal frequently becomes informalized by patients. The everyday process of entrance and exit, becomes part of an alternative cultural response to the formal practices of the institution. Patients as well as staff, operate within this system of flux.

The medical institution and the social world of patients are not two distinct fixed entities but have periods of contradiction and intersection. The everyday life practices of the patients have been integrated into the daily functioning and ordering of the clinic. The interface between these two worlds, the formal and informal expresses a sense of identity created by patients. The manner in which entrances and exits are 'read' by patients, represents a form of resistance and a re-scripting of the way in which entrances and exits are constructed by dominant medical discourses. Patients "hang about" and meet friends, children run in and out, all these alter the sense of structured order typical of medical institutions. The patients do not always conform to the medical institution's demands for discipline. The medical staff repeatedly instruct patients to lower their voices, to stay in the designated areas and to wait for their turn and name to be called out.
A nurse yells above the din of voices:

> If you don't keep quiet you won't hear your name being called and you will have to come back again tomorrow. So please try and be quiet.

She further elaborates :

> Patients often wander outside and then it becomes difficult and time consuming. We have to send someone to look for them outside. As a result of this, they often miss their turn".

A further indication of the often informal entrance into the hospital is the continuous movement of patients, children, friends and dogs in and out of both the entrance and exit. There is a constant stream of movement between entrance and exit as people drop by to greet staff, attempt to locate a friend, or relay a message. Some patients often merely come to "hang out" expressed colloquially by Piet and Brandon :

I meet two young men, sitting outside the dispensary with a ghetto blaster and a large dog. They are sitting separately from the other patients. Piet has a scar over his right cheek. I ask him if he is ill and whether he is here to see the doctor.

Piet: *Nee ek is net hier om te wag vir my girlfriend. Ek sal my nooi hier ontmoet, sy moet haar pomp kom haal vir die asthma.*
I am here waiting for my girlfriend. I will meet my girlfriend here, she has to collect her pump for her asthma.

I ask Piet about the scar on his face.

Me: *Wat het met jou gesig gebeur?*
What happened to your face?

Piet: *Dis daai skollies in die Wynberg. Hulle het my met 'n mes gesteek.*
It was those gangsters in Wynberg. They stabbed me with a knife.

I ask his friend Brandon, if he is also waiting for medication.

Brandon: *Nee, ek is by die skool.*
No, I am at school.

Me: *Behoort jy nie nou by die skool te wees nie.?*
Aren't you supposed to be at school?

Brandon: *Dis nou break time.*
It is now our break time.

I realize that he is playing truant and that there are no other schoolchildren around.

I discover later, that there is a problem in dispensing medication in his girlfriend's absence. I overhear the nurse saying :

Sister: *Dis onwettig, jou nooi moet haar eie medisyne kom haal.*
It is illegal, your girlfriend must come and get her own medicine.

Piet appears to accept this situation without any resistance and leaves shortly afterwards.

Me: *Wat gaan julle nou doen?*
What are you going to do now?

Piet: *Moenie worry Mevrou, ons sal nou weer in die rondte sit en sy kan maar haar eie asthma pomp kom haal. Dis nie 'n probleem.*
Don't worry Madam, we will go and hang about and she can come and get her own asthma pump. It's not a problem.

Piet and Brandon were quite happy to pass the time sitting in the day hospital with no real purpose in mind. A visit to the day hospital was an outing which included bringing along the ghetto blaster and their dog, forming part of the daily routine of hanging about in the neighbourhood (*in die rondte sit).*

2.3 STRUCTURE AND DESIGN OF THE CLINIC

The day hospital is divided into two distinct sections, one falls under the Cape Provincial Administration (C.P.A., the medical section) and the other falls under the Regional Services which runs a Primary Health Care Clinic consisting of the Family Planning Clinic and Baby Clinic. Other services include a monthly Psychiatric Clinic, weekly Dental Clinic and weekly Physiotherapy and Occupational Therapy. Community services such as home visits are also provided.

2.3.1 The Waiting Room and Reception (see Figure 2)

The clinic is designed so that one enters a large waiting room with a glassed-in reception area. Behind the reception desk is the receptionist's office filled with large open filing cabinets containing the patients' green folders and files. The

receptionist's office contains two large wooden tables situated at the back of the room and forming part of the offices of the Regional Health Services which is run by a Community Health Nursing Sister. The receptionist proudly shows me the recently acquired fax \ Xerox machine which is kept under lock and key. She informs me that previously all photocopying had to be done at the nearby library. In contrast to the outside waiting room there is a sense of order and an air of importance.[3]

The waiting room is large and starkly furnished with long rows of wooden benches all facing in the same direction. There are numerous posters on the walls and above the reception desk a clock which I notice is not working. To the left is a small barred window which opens into the dispensary.

2.3.2 The Dispensary

On the opposite side of the waiting room is a small barred window which opens into the dispensary, therefore ensuring that patients are able to access the dispensary from within the waiting room only. All medications are dispensed by a nursing Sister. There is a general sense of order and efficiency. In contrast to the treatment and consulting rooms, the dispensary is well supplied and there is a large selection of medications. This appears to be a contradictory phenomenon. On the one hand there are repeated references to the inappropriate dispensing of medications, yet on the other hand the dispensary is well-stocked indicating no apparent restrictions or constraints on the dispensing of medications.

Medicines are placed in pre-printed plastic bags with directions about the quantity and frequency of use. There are multicolored labels and instructions hanging from the shelves as well as various notices reminding staff about patient education particularly in connection with drug compliance. The dispensary serves a dual purpose and functions as the offices of the Sister in charge of the day hospital.

[3] Sister Joan is the receptionist \ clerk and the key figure in this domain.

2.3.3 The Treatment Room

This space is reserved for medical treatments such as wound dressings, blood pressure and weight monitoring and breathing treatments. The powerful symbols of medicine and its technology create a sense of authority and presence. This is a well defined space where the boundaries are clearly demarcated between the formal medical domain and the outside world. The room is dominated by numerous medical artifacts; a large oxygen cylinder, instruments for measuring blood pressure, for examining eyes and ears, needles, syringes, bandages and numerous items used in the practices of writing, diagnosis and corporeal description. The room is small and staff repeatedly refer to their cramped working conditions. There is one bed, a wooden chair and a footstool for patients to sit on. On my first visit I record in my fieldnotes:

> The treatment room is crowded, filled with patients, equipment and other medical paraphernalia. There are numerous posters on the walls pertaining to the prevention of infectious diseases. The room is clean and equipment is rudimentary. There is an ill- looking patient sitting on a foot stool receiving a breathing treatment while reading a novel. I note that this is the only time that I see any patient reading a text apart from a few patients that I observe reading pamphlets while waiting in the corridors. In close proximity and in the same room are two nurses, one is doing a dressing on a screaming baby, while the other is changing an abdominal dressing. I notice that there is no sense of privacy nor curtain to separate the three patients. The nurses acknowledge the unsatisfactory situation mentioning their cramped and "basic" working conditions. The contrasts with my North American experiences are vast and I am conscious of this (Fieldnotes, 21/6/95).

I note that this is the only time that I see a patient reading a text, apart from a few patients who hold the odd pamphlet or magazine in the waiting room.

All the texts and posters on the walls are directed at the staff with the exception of an eye examination placard supplied by General Optical (see Plate1). There are two placards, the first contains letters of the alphabet and the second consists of various childlike images. I notice a birthday cake with three candles, a tractor and a telephone. I assume that the second placard is directed at children who are unable to decode the letters of the alphabet. I ask the nurse in the treatment room whether it is

perhaps not used for patients who are unable to recognize the alphabet and she informs me that it is intended for children but is occasionally used for adults.

> We sometimes use it for the black people who come from the squatter camps. You see, most of our patients can read. It is only some of the African patients and older Coloured patients that have difficulty in reading the letters.

Her language is infused with racial subtexts. Illiteracy is associated with race, poverty and informal settlements. Similarly, many of these childlike images could be interpreted as infantilising adult patients, in which the image of a birthday cake would be out of place. However, the staff operating with limited budgets have clearly improvised and utilized their available resources.

2.3.4 The Doctor's Consulting Rooms

There are two consulting rooms. I did not spend much time in these areas, thus my descriptions are brief. The rooms are small and fairly standard with a view of Hout Bay harbour. I sense that this is a quiet space, a place of sanctuary with few interruptions. Hospitals are not private places but in the lives of the people in this community the brief time in the doctors' consulting room with the one-to-one contact can be a private moment, insulated from the harsh realities of their daily lives. Annie, a regular visitor expresses the following sentiment:

> You know Miss, it's nice to be able to talk to the doctor. She listens and is then able to help me. It is nice and quiet in that room, there are no children and other people asking for things and such.

2.3.5 The Baby Clinic (see Figure 3)

The Baby clinic is housed in a large room with a view over Hout Bay Harbour. The quality of spaces allocated to the Baby clinic is considered to be inferior by the staff interviewed. These spatial concerns were first voiced by the nursing Sister in charge of the Baby clinic, though none of the patients raised the issue of confined spaces or lack of privacy. Consultations are located in cramped and convertible spaces, i.e. ones that are converted into other functions on a regular basis. The Baby clinic is shared with Family Planning, educational classes for student nurses and also functions

as the office of the Regional Nursing Services. This contributes to the feelings of frustration voiced by the nursing staff who often judge the status and credibility of their work by the size and quality of physical spaces allocated to them. This can be inferred by their frequent referrals to the overcrowded and poor working conditions. Sr. G. informs me that the Health Authorities are planning to restructure and rebuild their working areas.

> Things will be so much better once we have larger premises. It will make our work so much easier and the two of us won't have to share consulting rooms any longer. I can't wait for them to start the remodelling.

The spatial dynamics in which two nurses share the same consulting room leads to little sense of privacy and confidentiality. The room is furnished with two large wooden tables pushed together and positioned opposite each other so that both nurses sit facing each other, while patients are positioned with their backs facing each other. Examinations and interviews between patients and staff take place concurrently. The room is noisy, filled with babies' cries and numerous interruptions; phones ringing, stray dogs wandering in, as well as frequent interruptions by other staff members.

2.3.6 The Family Planning Clinic

This room is converted into the Family Planning clinic on a Monday and Tuesday afternoon, in the mornings it serves as the Baby clinic. My observations and interviews in the Family Planning clinic took place in the space outside the consulting room. The area assigned to the initial entry into the Family Planning clinic is situated in the corner of the waiting room near one of the exits. This space is furnished with a large wooden table, on top of which is a scale; a box containing the patients' files and another into which patients place their family planning cards in numerical order.

2.3.7 Tea Room

The tea room is sparsely furnished. This is the only place where staff are physically separated from patients. "Tea time" forms an integral part of the daily rituals of the clinic. I am invited into the tea room with each field visit and the staff pour my tea. The formal and official face is present in the tea room. There is a ritualized hierarchy

surrounding the tea- drinking event, the doctors receive their tea first followed by the more senior nurses. Sr. A admonishes one of the junior nurses for not informing Dr.L that his tea is ready. I note that even in the tea room, medical staff call each other by their professional designations, Sister and Doctor.

> They continue to address each other as Sister even in non hospital- related events such as the purchase of a car. Sr.A discusses with another nurse the price of the car she plans to purchase and whether it is a feasible investment. Throughout the entire conversation they do not call each other by their first names. In fact, I do not know their first names and I have been coming here for a while now (FN., 17/11/95).

2.3.8 The Kitchen and Manna shop

The kitchen is seldom used. I saw the occasional patient drinking a glass of water or surreptitiously smoking in the kitchen. Run by a non profit organization, the Manna shop is situated alongside the kitchen. Foodstuffs are sold at a reduced price and I notice patients and other community members popping in and out to buy biscuits, sweets, chips and cooldrinks. Access into the shop is prevented by burglar bars and the purchasing of goods occurs from behind the burglar bars. I am aware of one burglary that has occurred during my field work.

2.4 LITERACY PRACTICES WITHIN DISCURSIVE DOMAINS

I have provided a description of the spatial location and design of the different spaces within the clinic. This section introduces the various texts and corresponding literacy practices within four discursive domains; the Reception and Waiting room, the Dispensary, the Baby and Family Planning clinic and the Treatment room.

The term **domain** as used in sociolinguistics, refers to "spheres of activity" which are under the sway of "one language or variety"(quoted in Grillo, 1989: 4). Barton (1994), uses the term to explore the position of literacy, as opposed to language. Different literacies are associated with different domains of life, such as home, school, work and church. There are different places in life where people act differently and use

language differently. I work with Baynham's concept of domains of literacy ; "as social space in which literacy practices are embedded" (1995:68) as it provides an initial 'structuring' of the social context of literacy practices in the clinic. Each domain does not necessarily have its own distinct literacy practices. Many literacy practices emanate from the domain of the home and penetrate other literacy domains. The home is the centre from which individuals venture out into other literacy domains. I argue that the "community" as an extension of the home is always present in the discursive domains of the clinic.

I attempted to link texts and literacy practices to specific domains of literacy to provide a more coherent understanding of the diverse practices encountered. However, identifying or linking domains with literacy practices has the potential of creating fixed and static entities allowing for little movement, interaction or overlap between domains. I take cognizance of this and hope to indicate through my data how certain literacy practices assume differing meanings and intent in the different domains.

2.4.1 Domain 1 : Waiting Room and Reception

In mapping who does what reading and writing in this domain and in the clinic in general I come to the conclusion that most reading and writing is performed by nurses, doctors and the receptionist. Thus literacy depicted by the encoding and decoding of texts is performed by representatives of the medical institution, within the dominant medical discourse.

The reception area and waiting room form the nexus of bureaucratic practices and literacy practices, yet very little reading and writing is performed by patients. This is the official face of the institution. It is here that the patient is constructed bureaucratically and 'read' and recorded into the medical institution. The performance at the reception desk, the bureaucratic transactions of registering, filling in forms, being seen in the correct order and according to disease stratification "emergency's first" and signage, all replicate in miniature Goffman's (1961)

description of the total institution. [4] These induction procedures are similar to Goffman's descriptions though more integrated into the patient's everyday life structures.

The official intent is to separate and remove all forms of writing from the patient as part of the process of induction into the medical institution. All writing is performed by the receptionist and by the medical staff. These normalizing textual procedures are the first attempts to register the patient as an institutional text within the record-keeping circuits of the institution. These normalizing procedures consist of being assigned a number, a place in the queue structure, a disease typology and a financial category according to income.

I identify different genres of visually displayed texts in the forms of signage and notices, official texts, posters and other miscellaneous visual displays. The entire reception area is surrounded by handwritten notices and signs, authority is designated by these official signs. I count at least eight handwritten signs. In entering this space, patients are confronted with a display of signs situating them physically inside a particular world of signs.

In contrast to the outside space where the only signage is a small printed sign stating Hout Bay Day Hospital, the signage in the inside space is prescriptive. This is evident in displays of notices ranging from:

- Attention please : Please sit in the waiting room until your name is called by the staff (see Plate 2).
- Ask for receipt upon payment - show receipt to Sister or Doctor at point of treatment.
- Patients must declare their income at each visit
- Patients who do not respond when called will be required to wait until remaining patients have been seen by Doctor. Thank you Sister- In -Charge.(see Plate 3)

[4] Goffman talks about the variations within total institutions. The day hospital cannot be viewed entirely as a total institution as patients enter on a voluntary basis and for short periods of time. It can be considered as an adjunct to and fashioned on the total institution.

- Please use the bins.

None of these instructions apart from the first one are strictly enforced. Patients are required to pay R 8 for each visit and if they are unable to pay they receive a receipt and are expected to pay on their next visit. I was later to meet Sarie who told me that she seldom paid and produced a wad of receipts tucked away in her brassiere. I also never witnessed any of the nurses or doctors requesting to see the patients' receipt of payment prior to treatment.

In spite of the prescriptive tone of these notices, patients have negotiated a situation whereby the rules and regulations are not strictly enforced. This is a further instance of the culture of entitlement or of "working the system". This will be explored further in Chapter Three. Some of the patients might pay the R 8, but others who are well-known to the staff and are identified as having multiple problems associated with alcohol abuse, domestic violence and chronic illnesses are not pressed to pay. This is reflected in the following interview with Sarie, a woman of fifty-five who never had the opportunity to go to school. She has one blind eye, a deformed leg and uses a walking stick. She is emaciated and has cigarette burn marks on her dress. She coughs throughout the interview.[5]

The interview is conducted in the room adjacent to the waiting room. Sarie appears to know her way around. I had seen her earlier drinking tea and eating biscuits in the kitchen. I assured her that she would not lose her position in the queue. She replied, "Don't worry, *Joan ken vir my*" (Don't worry, Joan knows me).
Our interview ensued in Afrikaans interspersed with English.

Me: Sarie why are you here?
Sarie: I am here for high blood.
Me: What happened to your eye ?
Sarie: Another child hit me when I was just small. I took no notice now my eye is like that.
Me: What is your age ?
Sarie: I do not know, but you can look on my card.
Me: Do you know the year that you were born?
Sarie: Excuse me.

[5] I have translated this interview from Afrikaans to English, but have indicated instances of code and mode switching, particularly as it relates to the vernacular use of the language.

I repeated the question. She responded with, November 05, the rest was unclear. I then asked, 1905 and she answered, "yes."

Me: That makes you ninety (laughing).
Sarie: Yes, I'm old now.
Me : Did you ever go to school? (I repeated the question).
Sarie: I did go, but not too much.
Me: Can you read and write ?
Sarie: No, I can't read.
Me: How do you manage?
Sarie: Manage with what ?
Me: Like going to the shops and getting your pension?
Sarie: I just ask thirty-five cents, something like that. If I want something that costs it, then they say thirty- five cents. If I haven't got it, I haven't got it. If I haven't got it, I leave it because I can't take it if I haven't got the money.

It was difficult to hear what she was saying, she spoke softly and code-switched to Afrikaans. I tried to clarify what she was saying but then decided to continue. Not having money was interspersed throughout the interview at the end of which she asked me for twenty cents. A further life history was obtained. She has no family or children and boards with a family in the neighbourhood. She was born in Johannesburg and came to the Cape as a young girl of twelve to look after "Masters children under Wynberg." She did not know what had happened to her mother, her father was a soldier and "left her with that *baas*(boss) whose children I looked after." A few interruptions followed, we continued. I asked to see her clinic card. She gave me a piece of paper which was folded up in her overall pocket. The paper that she produced was a receipt from the out- patient clinic containing the date ; folder number ; name ; amount due for this visit and signature \ clerk, (here Sr. Joan had signed for Sarie). "Outstanding fees" amounted to R8.

Sarie: This I must pay. I have left my card at home but they know me at reception.
Me : Do you know how much you owe?
Sarie: Yes, but I don't have the money to pay.
Me: Do you pay next time?
Sarie: Maybe if I have it. (She did not know the amount). It does not matter. I give what I have. One can't expect anything for nothing, one must pay but how can I pay? I only get my disability and then I must also pay my "*dood*" insurance, (death insurance).
(I sense that in her own way she is "working the system". She informs me that she has a friend that helps her with transactions of a monetary nature).
Sarie: I know that old *Oupa*(Grandfather) who goes with me to fetch my disability.
Me: How do you manage at the disability office?
Sarie: We *mos* know those people. They give us the right amount and then Oupa checks it. If they try to rob me then I say, hey you have robbed me and then they won't do it again.
Me: How do you know which card is which?

Sarie: (Laughing), What do you mean. I put them all together in one place. In my suitcase, if I need something then I go and fetch it. I keep my pills there as well. (She then looked in her brassiere for another piece of paper but could not find it). Joan knows me very well. I just go there and she knows where my folder is as I've been coming here for a long time. I come here often, just when the doctor say me to come and when my tablets are finished (FN., 24/11/95).

The above interview further confirms the manner in which the formal has become informalized. Sarie is known to staff and patients who often buy her biscuits and waive certain rules. By using everyday knowledge and her own socially-embedded or local literacies to mediate between socio-economic difficulties and requirements in terms of health care entitlements and treatment, Sarie is able to by-pass the need for formal schooled literacy. The fact that she is unable to read and write appears to be no less inhibiting than her need to ensure adequate medication, treatment and continued disability payments. Thus, despite her inability to decipher print she is still able to engage with the system. Sarie has come to know who she needs to access in order to receive continued treatment; Sr. Joan to locate her file, the doctor who tells her when to come, and lastly the "old *Oupa*" to assist her with disability payments. It is often the most marginal populations that have the most frequent and intense contact with the state's institutional and welfare structures. Through practice and repeated interactions with state bureaucracy an intimate knowledge of its workings is acquired.

The didactic tone and message of officialdom is further informalized through the diverse encoding of official texts. The notices are handwritten and signed by the "Sister in Charge". There are a few grammatical errors and makeshift corrections to some of the notices. For example:

> Attention please - Please sit in the waiting until your name is called by staff.
> The word " room" is missing.

The entire reception area is glassed-in with the exception of a small area through which the receptionist is able to place her head and converse with patients. The manner in which she is physically positioned behind a glass window surrounded by signage and official texts provides a form of structural distancing.

The central figure in this domain is "Sister Joan". She is not a nursing Sister, but is called Sister, due to her religious affiliations and hierarchical positioning in the Baptist church. She is surrounded by bureaucratic and official discourse and text. All writing is performed by the receptionist who becomes the literacy mediator between the patient as bureaucratically constructed and the institution. In addition she is the official gatekeeper having direct access to the artifacts of medical literacy ranging from the folders, files, forms and clinic cards to communicative technology, the fax and phones, and even the dispensing of condoms. Yet her position is also one of local literacy mediator. She is a familiar and respected figure in the community, yet her position as literacy mediator and as official gatekeeper is constructed by relations of power. As representative of the dominant institution and gateway to their resources, Sr. Joan, as literacy mediator, has a particularly authoritative voice. She decides whether to waive payment and whether patients who have not followed the correct procedures can still be seen. This can be seen in an incident with a woman I had interviewed. She arrived late, yet requested to see the doctor urgently as her child was ill. She appealed to Sr. Joan who subsequently directed her request to the nurse-in -charge. The child was subsequently seen by the doctor.

Interwoven with power relations are the processes of literacy mediation. Sr. Joan performs the task of what Schiffrin (1994) has referred to as the "writing for the other".

Schiffrin[6] shows how experts in formal codes and modes of communication do the reading and writing for clients and relates this process to a particular "self \ other alignment" which defines communicative roles. The formal institution makes use of standardized modes and codes of communication such as forms, files and other medical documents. The clerk or nurse is expert at translating the local or vernacular discourse into formal register or bureaucratic discourse. The clerk is familiar with the bureaucratic codes used and performs the function of writing for the other, other being the patient. This writing for the "other" is not merely a convenience as claimed by Sr. Joan, but is linked to the process of induction into the medical institution and

[6] In Malan, 1995.

lends to the general order, discipline and structuring of the clinic. Thus practices of induction such as temporal scheduling, spatial organization and body surveillance by the medical institution are exercises in, and displays of the power of institutional literacy, with which the patient must conform. The following instructions are displays of institutional literacy with which the patient must comply.

Positioned alongside the reception window is a box consisting of three compartments with a handwritten sign attached to it with the inscription:

- Pille
- Dressing
- Dr.

I describe below, from my fieldnotes, impressions and the hidden literacy practices observed.

> Patients are instructed to place their cards into the appropriate compartment. Patients follow the procedure of registering at the desk, producing their clinic cards and placing them in the appropriate box. Occasionally this procedure is not followed and Sister Joan organizes the cards accordingly. The only writing I see is the patient's signature on hospital forms or receipts. The patients who can read and write, also have their forms filled in because according to Sr. Joan: "It is much quicker. I don't have time because nothing is computerized, everything is done manually. So, I don't worry if they can write or not, it does not really matter. I am too busy to wait for them to fill in the forms with each visit. Anyway, I know many of these patients, they have been coming for a long time" (FN.,22/8/95).

Thus bureaucratic transactions are at times personal and most patients are well acquainted with Sr. Joan who has strong community ties. Her house is situated in close proximity to the hospital. According to the Sister in charge, Sr. Joan knows most of the patients by name as she is a key figure in the Baptist church and "zealous in her recruitment efforts".

All official texts such as patient's files, clinic cards, registration cards and receipts play an important part in the daily rituals of the clinic. It is not required or expected of patients to be able to engage with official texts in the form of standardized reading and writing capacities. Patients have learnt, through mobilizing their own vernacular

literacies,[7] which texts have currency, and which do not. Which texts are important vehicles for gaining access to health care entitlements and which are of lesser significance. This has become an acquired practice and part of what I term the culture of entitlement and the ability to work the system. Important texts are kept in safe places. Sarie keeps her clinic cards in her brassiere and another patient keeps a suitcase under her bed filled with all important documents. Therefore in looking at the relationship between literacy practices and texts, the focus is on how patients use medical texts and literacies to negotiate and mediate their position within the clinic.

The relationship between literacy acquisition and socially embedded literacies is crucial to an understanding of literacy practices within the hospital domain. The literacies are embedded in the daily social practices of the patients and part of the logic of everyday hospital practice and procedure. Patients have acquired these discursive skills through practice and routine such as placing their cards in the appropriate box, returning on a certain day and taking medications at a specified time.

An example of separation from the medical texts is the patient's interactions with official texts. There is very little contact with the official texts represented by files, folders and recorded medical details. These documents are always written on by representatives of authority and never by the patient. These medicalized texts belong to the medical institution, and are part of the ordering, classifying and quantifying apparatus of the institution. They are emblems of power, becoming part of secret knowledge and integral to the functioning of the institution. They are the literacy practices that are hidden from the patients.

Health Suggestion Box (see Plate 1)

The Health Suggestion box is situated in the corner of the waiting room. Unfortunately I was not able to observe any interaction or community meetings around this literacy event. I asked the Community Health Sister about the Health Suggestion box. On numerous occasions I had found the box to be empty. Pamphlets

[7] Street (1993) defines vernacular literacies as having their roots in everyday life practices and which can be seen as emerging in response to dominant literacies. This is not too dissimilar to my understandings of social literacies.

on a range of issues are placed alongside this box which is situated on a table next to the area were the babies and mothers attending the Family Planning clinic are weighed. Above the Health Suggestion box is a hand written poster. The poster discusses the Health Forum and the RDP (Reconstruction and Development Plan) and the need for members to become involved in local community issues. Sister G informs me:

> Everyday we inform patients to voice their complaints via the Health Suggestion Box, but no one does. I have informed patients to write down their complaints and place it in the box. (I asked her if the patients were able to write and she states that most were able to read and write). We even provide pen and paper. I told patients that they need not write their name on the suggestion form but they still do not write anything. They are used to us doing everything for them. We have had a poor response, a lot of education is still required.

The above statement reflects the perceptions that staff members hold about the patients and is premised on tales about the past and the grand narrative of apartheid. Lack of response is attributed to apathy and poor education. Patients have been homogenized by the medical domain as an apathetic and disinterested population, which is attributed in turn to lack of education. Paradoxically, patients appear to be responding in the manner in which they are depicted. I question the significance of the "silence" interpreted as apathy by staff. Bakhtin (1981) has explored the significance of silence. Silence is a form of being in dialogue and most often a way of confronting the monologic voice of total institutions.

2.4.2 Domain 2 : Family Planning and Baby Clinic

Pamphlets are delivered by different organizations and are placed by the staff in various spaces, mainly in the space reserved for the Family Planning clinic. I notice various pamphlets distributed by the Association for Voluntary Sterilization of SA. The pamphlets are in English, Afrikaans and Xhosa. The Afrikaans and English pamphlets are separated by gender and colour coded, pink for women and blue for men and illustrated by a diagram of the male and female reproductive organs. The Xhosa pamphlet is yellow. There are no diagrams of the reproductive organs, nor are

they separated according to gender. In this pamphlet both men and women have been denuded of their body parts. I ask a woman from the Association for Voluntary Sterilization why this is the case. She informs me that African men and women are not comfortable with looking at the reproductive organs in such a public manner. I do not observe any patients reading pamphlets apart from one woman with a pamphlet about head lice found in Britain. She tells me that it is "good" to read these bits of information and will take it home. I never saw anyone leaving the hospital with any pamphlets. The pamphlets seem to have little meaning in the daily lives of those that they are directed towards. The texts are infused with medical and essay-text literacies.

The appointment cards, Baby clinic and Family Planning clinic cards are fixed texts, the texts that have the most currency. There is a sense of permanence and ordered logic in the manner in which they are interacted with. Patients remember to bring them, place them in the correct containers and follow the procedures by placing them in numerical order as part of the queue structure. There is a permanence and temporality to these cards, they position and structure identity and enable access to health care entitlements. The dates and times inscribed on the cards inform clients to return every three months for their contraceptive injection. This is an important event, as it safeguards their reproductive status.

My initial understanding was that patients were not interacting with these texts. Few patients knew the name of their contraceptive injection nor voiced concern that they did not know. Yet most were able to read the name Depo Provera off their clinic cards. As events began to unfold I realized that patients followed the registration procedures which required simple numeracy practices and returned timeously for their injections. This appeared to be a contradictory situation, on the one hand they interacted with these texts, in safekeeping their cards and by remembering when to return, yet on another level they did not interact by reading or memorizing the name of their contraceptive injection. I soon discovered that this was not necessarily a paradoxical situation, the medical domain had usurped this literacy practice by not informing or educating patients about the name, side effects and how the

contraceptive works. Thus through the construction of expert medical knowledge certain literacy practices had been appropriated by the discourses of medicine and consequently patients were placed in a position of distance from their own bodies. Recordings in my fieldnotes begin to deal with this apparent contradiction.

> The area assigned to the Family Planning Clinic is situated in the corner of the waiting room near the side exit. The staff are busy preparing the space for the Family Planning clinic. In the corner of the waiting room is a table with a large box containing the patients' files and another into which patients place their appointment cards in numerical order. Everyone appears to have a good grasp of this system. There are two weighing scales, one for adults and one for babies. The cards are numerically ordered in piles. Procedures are clearly structured by means of rows, queues, cards and folders which not only simplify matters for the staff, but give the patients the security that they can rely on the system and will be seen in an ordered fashion. The nurse calls out their name, they are weighed and then proceed into the Sister's office where she records the patient's blood pressure and administers the contraceptive injection, Depo Provera. There is little verbal communication between staff and patients. They are not informed of their blood pressure nor do they ask. One of the side effects of Depo Provera is weight gain, yet none of the patients seem to comment on this phenomenon, with the exception of one patient who claims: "I don't worry if I gain weight. (*Ek worry nie as ek wig optel.*) It's better to be safe.(*Dis beter om safe te wees*) (FN,6/9/95).

Patients enter a visual system of **posters** displayed on the walls of all domains. There is no vacant or empty wall in the entire hospital, even the kitchen has posters on the wall. Posters are numerous, varied and with no real logic or order. They are often randomly placed as confirmed by the staff. These visual texts are not visibly interacted with, yet returning to my previous conceptualizations of literacy as explicitly or implicitly ideological, the display of posters on the walls can be viewed as a display of medical identity and hegemony. They construct the patient in a world of visual imagery which is varied and often imposing in the choices of visual display.

I observe a patient waiting outside the psychiatric clinic, restlessly walking up and down the corridors. She stops to peer at a poster about immunization. I ask the patient what she is looking at :

Patient: *Dis 'n mooi prent van ' n baba.*
It's a nice picture of a baby.

Most patients need not actively engage with any of these posters and in all my interviews most patients did not relate to any of these forms of visual display. Yet in spite of these overburdened significations, visual display did have an important part to play in the construction of the day hospital as a community and medical space and I will now explain how.

Posters form the walls of the institution as part of the institutional display and the manner in which the clinic is presented as a space for public health discourse and prescription. These spaces have become overburdened with meaning through the abundant and disordered visual displays. They have consequently lost their impact in terms of their educative function, but have provided and created a space which positions the patient and staff into a medical space of public health discourse.

Sister G recalls the time when all the posters were removed from the walls and how they were subsequently empty for two weeks. Patients did not notice these changes. When asked if they had noticed anything different they had said, No. However, Sister A states that :

> During AIDS week when we put out new posters, we had some response. A few patients looked at the AIDS posters and asked some questions.

This was later confirmed by a patient during an interview.

> I don't really notice these posters. But those ones about AIDS and such things are important and the young people should read those things as well.

Sister A informs me that I can remove any posters useful to my research project.

> I am tired of these posters, anycase patients take no notice of them. You are welcome to take them off the walls or ones that might be useful to you.

Another staff member directs me towards a large empty room which serves multiple functions, one of which is the monthly psychiatric clinic. Rolled up posters are stacked on the floor, on the shelves and inside the cupboards. Some have been used and others are still waiting to be displayed.

> Here are lots of posters. You are welcome to take whatever ones you like. Here is a nice one on healthy eating particularly about potatoes as a good source of nutrition. I usually just go to the local supermarket and ask them for nice posters about healthy eating.

Why I ask do the staff persist in displaying these posters if they are "tired" of them? Have these forms of visual display become overburdened social signifiers to patients and staff alike? I am aware, from my own work as a nurse that various organizations deliver posters and pamphlets to most health care centres and that they are often displayed without any real sense of purpose or plan. Yet these visual displays are not solely decorative, they are manifestations of spaces of visual and material representation providing the capacity for creating and claiming this space as official hospital space. The abundance of official signage and instructions pertaining to induction procedures and the overwhelming display of texts (posters and pamphlets) serves to create a sense of prevailing medical space. There "silence" and display signify their sense of power.

Other posters inform patients about the potential dangers of sexually transmitted diseases and unprotected sex. Such as the one issued by the National Public Health Centre AIDS Working Group titled:

DON'T GET CAUGHT....WITHOUT A CONDOM

Below this caption is a picture of two young adults in school uniform half undressed lying on a sofa. In the doorway is an older woman with her shopping bags. She has arrived home and presumably interrupted them. In the corner of the poster is a picture of an inflated condom.

Plate 4& 5

In these posters, visual representation is translated into material and real life experiences, by illustrating the dangers of a child playing with fire, warnings about how to prevent burns and protect children from toxic substances. In this instance, the message is explicit and does not require reading skills. Miscellaneous posters and pamphlets such as notices advertising christening robes, RDP meetings and the CMC

[8] RDP fund pamphlet are indications of the wider community's presence in the medical space.

2.4.3 Domain 3: Dispensary

Literacy practices in this discursive domain centre around the administration of medications. The most visible literacy practices are the nurses' instructions, both verbal and written. Instructions with regards to dosage and frequency are printed on plastic packets. The administration and instructions around medicines are brief and hurried. They are often provided in the form of a narrative such as; "this is the pill to make you strong", or, "this tablet is for the sugar sickness". The former refers to a multivitamin and the latter to diabetes. In other instances nurses provide instructions that are connected to time spacing, colour coding and identification according to somatic and locally shared meaning codes between staff and patients. Patients use certain genres of communication in their narratives, and in their identification of their medications and treatment. The communicative or linguistic codes such as; the pills for "sugar diabetes", the pills for "water", the pills for "high blood or "*hoe blood druk*" and medicine for "double pneumonia" are examples of local non- standard vernacular medical terminology used by patients and frequently by the nurses in their explanations. Nurses express the desire to provide an educative function when dispensing medications reflected by the following comment from the nurse in the dispensary.

> It is here that I would like more time for education and teaching patients but there is no time. We are always pressed for time.

What is important in terms of my argument is that literacy as reading and writing, is not in the forefront of these transactions. Patients do not appear to read the instructions or names off the medicine labels. Many patients however were able to read the instructions off their medicine bottles and if asked were able to identify their various medications. It was often through practice and locally shared meaning codes that patients identified their medications and their corresponding illnesses, illustrated by the following statement:

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[8] CMC Cape Metropolitan Council advising how to obtain loans for small businesses.

> I know this bottle is for the "*hoes*"[9] and this bottle is an antibiotic which I keep in the fridge. You see, as every few months my child needs this medicine. You know, he was born like this, always with a runny nose and chest problems.

The concept that there is no visible reading and writing opens up the space for variations of literacy. Camitta (1993) in her study of adolescent writings produced outside of the school environment argues that vernacular discourse is derived from "folk or popular traditions" and a lack of conformity to the standard. By vernacular writing she refers to writing that is traditional and indigenous to the diverse cultural processes of communities as distinguished from the uniform standards of institutions.

I argue that the vernacular literacy practices employed by patients such as evidenced by two sisters from Kronendal farm (discussed below) are in response to dominant medical discourse and are closely allied to everyday life practices. I meet two sisters from Kronendal farm, both had never been to school.

> My sister is here to see the doctor for her "nerves". I ask whether they have an appointment to see the psychiatrist. Yes, the letter is with the doctor. I ask her what it entails. She replies: I cannot read. But I know that I must bring my sister for her appointment to see the doctor because she is unable to talk. She understands everything but cannot talk. We talk our own "dom taal."[10] I ask how she manages to take her medications. She responds by identifying medications through size, shape and colour and distinguishes the different time sequencing. This is based on establishing a relationship between the main social activities of her day; (eating and sleeping) and those which correspond with the spacing of her tablets: You see they did not give me the name of the medicines so I have my own system. You see I take the white one, the one for high blood; one- one and then half. The small yellow one is for the "water". I take it one and one, in the morning and as I sleep (FN., 31/8/95).

The taking of tablets is not necessarily centred around or dependent upon being able to read the labels or linked to clock time, but is structured around daily social practices. Thus the focus is on the taking of tablets according to daily social activities

[9]"bronchial cough"
[10]"mute language"

and through a form of visual literacy,(through colour coding, shape and size) and not according to standard medical instructions such as decoding or deciphering the print on the medicine bottles.

Above the dispensary window is a poster of a doctor with outstretched empty hands and below this is the following assertion:

> Be prepared to leave this surgery empty handed. The doctor may not give you a prescription his advice may be all you need. You may be sure that if you really need one you'll get one.

The narrative of the poster suggests it is somehow wrong to expect medications with each hospital visit. The image of the doctor as a man of 'reason' and 'superior' knowledge is counterposed against the patients' irrational demands for medical hand outs. The message in this text is one that is to re-occur in the field and has a complex socio-political history. Warnings against expecting automatic handouts is further evidenced in discussions with staff who are concerned about the inappropriate use of medications, particularly antibiotics. These expectations form part of the culture of entitlement. This is further endorsed by the ubiquitous Superbug poster which is displayed in all areas of the hospital, ranging from the corridors to the Doctor's consulting rooms.

The Superbug poster is an extract from an unacknowledged British text, a medical journal or newspaper which warns doctors and "civilians" alike of the dangers of the overuse and abuse of antibiotics and cautions against the potentially lethal effects of misuse. The warning is depicted in the following extract:

> Because of their overuse, antibiotics have started the deadly invasion of the SUPERBUGS. (This is the caption above the poster). Antibiotics are a toxic time bomb if not used and prescribed prudently....Unsupervised dispensing in Third World countries also results in widespread over-use.

The entire article is a metanarrative constructed in medical discourse that seeks in the interests of rationality and progress to warn both medical staff and patients about the dangers of over-prescribing. The issues are complex and it would appear that the

staff are merely reinforcing directives from the central health authorities by placing these messages in every conceivable space. This poster serves as a form of surveillance and control to both patients and staff. It is thus strategically placed as a means to influence and manipulate the dispensing of "unnecessary" medications.

2.4.4 Domain 4 : Treatment room.

The texts on the walls are directed at the medical staff and are infused with medical discourse. The medical texts, symbols and artifacts claim this space as interventionist medical space. Patients are not required to interact with texts and are positioned in a relationship of dependence with the medical staff. Medical texts centre around the prevention of the spread of infectious diseases, AIDS, tuberculosis and hepatitis and what procedures to follow.

Medical literacy and intervention is experienced at its most intense level in this particular domain. Patients sit passively while their wounds are dressed, vital signs are recorded and their diseases are encoded and quantified into a form of operational medical literacy. The patient is read into the institutional memory as an assemblage of symptoms, signs and behaviors. Expert medical knowledge and technologies through their display of institutional power over patients' bodies have taken away the patients' need for their own literacy practices, whether schooled or local. Patients thus suspend their own literacy practices as expert knowledge is constructed and applied.

2.5 Conclusions

In conclusion, I return to my original understanding of literacy that it is not about reading and writing as isolated technical skill, but rather about social practice embedded in relations of power, agency, identity and the material and social realities of patients as experienced and lived.

The encoding and decoding of texts is not the central issue. Patients have, through practice and through their own local interpretations of the various medical texts, decided what it is that they need to know and when they need to utilize their reading and writing skills. These discursive skills have been acquired both through informal

practice and in literacy instruction at school. What is more important to the patients is not how to read and write as reflected in their role in filling in forms and their response to reading labels on medicines bottles, rather it is how patients use their own socially embedded literacies to mediate and gain access to health care entitlements and treatment and the discursive resources that they employ in order to do so.

CHAPTER THREE

"THIS IS MY FAMILY, IT IS LIKE MY HOME"

AN EXAMINATION OF LITERACY PRACTICES WITHIN SOCIALLY CONSTRUCTED SPACE

3.1 Introduction

The title of this chapter comes from Magda, a patient who talks about her daily life experiences in the community. I had seen her earlier, sitting on the steps outside the entrance to the hospital, chatting to two young mothers with small babies. I subsequently meet her in the waiting room.

Magda is sitting on a large wooden bench in the waiting room. A toddler is playing with a rubber ball at her feet. She places a pamphlet concerning head lice and scabies into her coat pocket. I initiate a conversation and her narrative follows:

> I was born in Hout Bay, my parents moved to the area from the countryside. My father was a fisherman and so is my husband and brother. They used to work for that *baas* (boss) who had a big fishing boat and then it was bought by one of those large factories, the Sea Products. Today you can eat that same fish at Snoekies. Miss, I don't want to move out of this area, not to a place like Mitchell's Plain. I can buy me a cheap house there, but I will know nobody there. We know each other here and I can visit my friends. We do not have all those entertainments but still we have our own. In my mother's time they used to stay at home and sing and play the guitar, now it's more TV and videos. Our men are away, so we have to all of us be friends. You see it is my home. I was born here. It is only the young people that move out of the area. This hospital is also like a home, it's friendly and such and we know a lot of these people. This is my family, it is like my home.

Magda's narrative reflects the central arguments of this chapter. Firstly, that each vignette forms part of a wider narrative, organized around metaphors of home, family and the everyday life practices of the people attending the day hospital. Secondly, the differing discursive positions captured through the narratives that I present are enacted, placed and positioned within particular social spaces. Thirdly, these narratives trace the process of identity formation around the place and the people. In this chapter I expand the notion of space and place as previously discussed in Chapter

Two, and explore the manner in which patients have claimed formal institutional space as community space. Space is narrated as a manifestation of collective identity. This happens within formal institutional space through the creation of a hybrid identity at the interface between the formal and informal spheres.

3.2 A narrative about the history and demography of Hout Bay.

It became evident throughout my fieldwork that members of the community were introducing significant aspects of their home environment into the hospital space. To provide a background to this and to contextualize and situate the day hospital within the larger community so as to provide a sense of **place** within which to explore the social relations constructed within **space**, I now provide a socio-political narrative of Hout Bay and its environs.

The details about history and demography should be read as an incomplete text. They are drawn from secondary sources and from the narratives of the people living in the area.

The history of the harbour community is linked to the development and expansion of the fishing industry and the need to provide housing for workers in close proximity to the harbour and fishing factories. Magda refers to her father, brother and husband as being fishermen. The community has a long history of fishing and throughout my time in the field I was to meet people who were in some way connected to the fishing industry. As early as 1944, Navid claimed that most of the inhabitants of Hout Bay had their roots deep in the history of the fishing industry.

> There are men in Hout Bay today, whose fathers before them lived and worked on the sea, and who have themselves been on the boats since they were boys (Navid, 1944:8).

The social origins of the fishing industry in Hout Bay can be traced back to the early history of the Khoi-Khoi people who gathered shellfish from the rocks and trapped fish in the estuary. Colonization was to alter and impact on indigenous fishing activities. The fishing industry expanded considerably in the post- war years. In 1946, smaller companies and factories amalgamated to form the South African Sea Products

Company which was largely instrumental in building and developing living quarters for their workers. More recently, the fishing industry has altered due to the decline in the fish resources. With dwindling fish stocks, the harbour has become more tourist-oriented. Mariners Wharf, which boasts South Africa's first fish emporium and other restaurants such as Snoekies and The Wharfside Grill, have become popular tourist venues.

Hout Bay harbour community, locally referred to as the fishing village, is a residential 'Coloured area', an enclave situated within the greater Hout Bay area. The total population recorded in 1994 was five thousand. The Hout Bay fishing community is described in the Community Profile as a "picturesque fishing village" [1]. On many levels this is an apt description and captures the natural beauty of the area, surrounded by the ocean, the mountains and the forests. Traveling through the area one cannot help but notice the surrounding contrasts. I recall my first impressions of Hout Bay :

> I approach the area, and travel slowly up the hill. The base of the hill is a hub of social activity and I tentatively manoeuvre my car amongst children, taxis, buses, bicycles and dogs. As I drive up the hill I encounter an imposing building, the mosque. I proceed further up the hill. I am further confronted by large ornate houses replete with burglar alarm systems and security warnings found in most white suburbs of Cape Town. In contrast, the genre of houses in the fishing village are structurally bleak and utilitarian. Even here the disparities are evident (FN., June, 1995).

The area is filled with contrasts and structural remnants of the apartheid regime and Group Areas Act of 1950.[2] Coloured people who resided in the now White areas of

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[1] The Community Profile is produced annually by the nursing sister in charge of Regional Health Services. I was given a copy for 1994. The Community Profile for 1995 was not available.

[2] The Group Areas Act of 1950 was aimed at the total urban spatial segregation of the various racial groups defined under the Population Registration Act. Towns and cities were to be divided into group areas for the exclusive ownership and occupation of a designated group. People not of the prescribed racial group were often forcibly relocated to the group area created for them. Those classified as Coloured, were moved out of what were often classified as White areas. The areas created for the

Hout Bay, locally referred to as the village, were eventually moved to the harbour village, prior to, and under the Group Areas Act.

Geographical constructs that correspond to the subtexts of race and class are detected in the conversations and narratives of both staff and patients. There is the White residential area of large houses and the "village" consisting of hotels, shops and restaurants serving the tourist industry and the local White community. The area around the harbour, the designated "Coloured" section, consists largely of sub-economic housing. The houses, initially built by the Sea Products Company, were built in stages and reflect differing design; the three-storied flats, row houses and maisonettes. All the houses have running water and electricity, though many of the older houses and flats have outside showers and toilets.

The houses are larger the further one moves away from the harbour and up the hill and are luxurious in contrast to those at the bottom of the hill. These houses are owned by the more affluent members of the community, for example, the mayor, a schoolteacher and a woman I meet who is a public relations manager at a large department store. Wealth and status correlate to movement up the hill, corresponding to spatial dichotomies of above and below. With the demise of the Group Areas Act in 1992 a few white families have bought property in the harbour area, as property remains less expensive than in the white section of Hout Bay.
The day hospital blends into the area and is not easily identified from the road. The significance of this phenomenon, whilst spatial in its implication, has symbolic meaning. The community has symbolically incorporated the hospital into its everyday spaces.

The topography and landscape of the area, bounded by the Atlantic ocean, the Karbonkel mountains and Chapman's Peak Drive (a mountainous road which curves around the peninsula) constructs and reinforces further geographical isolation and impacts on the political-economy of the area. The area is unique in that in spite of the

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Coloureds were situated on the periphery of White urban infrastructure thus further enforcing strict segregation.

Group Areas Act and forced removals, inhabitants were able to maintain a sense of cohesion and kinship as they were moved to the nearby harbour village rather than to the distant geographical constructs created under apartheid. The strong sense of identity in this community can be traced back to the long history of fishing in the area. Currently the majority of working adults are still employed in the fishing industry. A few of the women work in the nearby fishing factories, such as Sea Products and Speciality Sea Foods, though most of the women that I interviewed in the Family Planning and Baby clinics were unemployed.

3.3 Spatial analysis

I continue to work with multiple voices and the manner in which patients weave their own narratives around their experiences within the hospital. Literacy practices might not be visible in the form of reading and writing, but it can be argued that patients have refashioned and rescripted expert medical knowledge and literacies, not only for their own understanding of illness, but also for extra-medical purposes such as welfare entitlements, access to medical resources and in the creation of spaces of communal activity.

In the previous chapters I argued that literacy practices are embedded in the discursive practices of everyday life and that literacy is best understood as embedded in social practice. The term **embedded** signifies some space or place and has a connotation of rootedness in place (Hanson and Pratt 1995:7). Thus a spatial analysis attempts to uncover the social relations and social experiences embedded within space and the way in which social relations are experienced in and through space. I work from the premise that space is not simply an objective material reality, nor physical place, but is socially constructed. Space represents and signifies material and social relations. The day hospital is not merely a geographical nor institutional construct but a space that has symbolic meaning for many of its inhabitants.

While the day hospital positions the subject, whether patient or staff, in a socially constructed space, one cannot overlook the notion of agency i.e. how individuals as

social agents are able to create their own space and monitor and organize their own life -narratives.

Spaces following Lefebvre(1991), are inscribed or read by individuals. Certain spaces in the clinic are constructed by dominant discourses as **signified spaces** through their displays of texts and signage. These signified spaces are what I refer to as formal space, for example the treatment room, dispensary and the doctor's consulting room. Thus according to Lefebvre:

> The environment can be furnished with or animated by signs in such a way as to appropriate space, in such a way that space becomes readable (i.e. plausibly linked) to society as a whole(1991:144).
>
> Once brought back into a conjunction with a spatial and signifying social practice, the concept of space can take on its full meaning (1991:137).

The formal space is represented by the medical discourse environment, the institution itself with the symbols and artifacts of medicine of which medical literacy plays an integral part.
The informal spaces are those spaces that patients have claimed, albeit momentary spaces, carnival in the waiting room and in the corridors of the hospital, in the language and communication codes used by patients both inside and outside the building. Informal space often extends into the street and surrounding neighbourhood.

The categories of inside \ outside space, formal \ informal space and paradoxical space are useful in identifying and isolating particular socio-spatial relations. However, these spatial constructs are not definitive entities which neatly counterpose one another, rather they often overlap and interweave. This may be illustrated in the reclamation of formal institutionalized space into areas of informal, socialized or community space. For example, in Chapter Two I discuss how entrances and exits are informalized by both staff and patients and how this impacts on my understandings of the fading and restructuring of institutionalized borders. This idea will now be further extended by arguing that the clinic is reconstructed as community space; out of medical space patients create community space. Institutionalized borders are

symbolically traversed. Through the **spatial stories** recounted by staff and patients, social space has come to embody a combination of collective imagery of home and family resulting in the creation of a hybrid identity.

3.4 Narrating space

Spatial stories are often symbolic representations of patients' experiences within the various spaces of the day hospital and their experiences of medical literacies within these socially constructed spaces.

Spatial stories depict the manner in which space is narrated. Spatial stories are symbolic representations of place or geography, in this instance the Hout Bay harbour community. They depict a geographically conceived social world, a sense of closeness and seclusion.

I had assumed that the spatial stories would embody tales of distance and separation,[3] instead I encountered stories of proximity and closeness. The gap between the centre and periphery had on certain levels been bridged and a merging of the boundaries between inside and outside became evident. The displacement of the centred discourses of the medical institution had been replaced or reorganized into the discourses and lives of the subjects on the periphery.

The following vignette reflects the manner in which the hospital has been incorporated into community space.

> A young boy with a learning disability and speech impediment spends his afternoons at the hospital socializing with staff and patients. I have become accustomed to meeting him at my car or in the hospital driveway both on arrival and departure. Raymond, a boy of ten, greets me at my car and directs me into the parking lot. He is well known to the staff and has blended into the daily activities of the hospital. He often follows me around the clinic or joins me outside. He is eager to talk into my tape recorder. I have to really concentrate as his speech impediment is marked and he frequently stutters and has trouble forming words. I realize that his

[3] The sense of separation or displacement that I anticipated could have arisen from the legacy of apartheid, for instance, unequal access to medical resources and spatial segregation.

problem lies in forming words, not in comprehending the meaning of words. He code-switches and mode-switches throughout the interview, between English and Afrikaans and between different narratives. He commences the conversation in English, but soon switches to Afrikaans. I ask him to tell me something about himself, but he appears reluctant. Instead, he recounts the story of Goldilocks and the Three Bears. I ask about his family. He recites another story, this time the tale of the Three Little Pigs. He continues to shift between these two narratives and between English and Afrikaans. He informs me that he attends Ocean View Training Centre and provides detailed directions to the school. He gesticulates stating ; "now travel along that road to Wynberg, then at the third light turn left, then *jy draai net rond om die hoek, dan is daar die ander pad, nou draai links en dan kom jy links, dan net so bietjie langer, dan by daardie tweede robot draai regs en dis daar.*" [4] I ask him to do some simple arithmetic that I think is age appropriate. After completing the sums he states: "*Nou is ek backwards.* (Now I am backwards). I can't colour in or write nicely. At the school they gave me some clay to work with, but I like coming here. I also ride my bike here in the back."

It becomes increasingly evident that the day hospital is a place where this young boy finds a sense of security and a place or space where he can "feel at home". He avoids conversation about his family, instead he recites "classic" children's stories. [5] I ask Sister A about Raymond. She informs me that he arrives most days after school and often does odd jobs around the building. On one occasion I see him helping the cleaner sweep the entrance to the clinic. Whatever his social circumstances, he has chosen to spend his afternoons within this particular space. In his own way he is able to mediate between the formal and informal space. He sees me as an authority figure, perhaps as a teacher, and thus attempts to converse in English. Yet he eventually switches to the informal (Afrikaans),maintaining a semblance of formality by performing simple numeracy tasks and reciting stories possibly taught at school. The result is a hybridization between the formal, as represented by his use of English and classic children's stories(schooled literacy) and the informal (his own vernacular and in his interactions with staff).One can argue that code-switching between English and Afrikaans is linked to identification with the dominant discourses of medicine and

[4] You go just around the corner, then there is another road, now turn left and then you come left, then just a little longer, then at that second robot turn right and it's there.
[5] The children's stories that he recounts is an example of trans-cultural penetration into this community. These are the same stories that I learnt to recite as a child.

authority. My presence and the use of English as opposed to Afrikaans is symbolic of authority, schooled literacy and more specifically expert medical knowledge.

An important aspect of literacy mediation is code-switching and mode-switching. Patients participate in events which involve shifts between Cape Afrikaans, the local vernacular, and standard Afrikaans and English used for more formal communication with medical staff. Numerous other instances of code-switching occur throughout my interviews and I will discuss further examples. Language and social identity are issues that re-occur. Speaking English in a predominantly Afrikaans speaking environment is a form of cultural capital, and an identification, however temporary, with the dominant discourses of medicine. Afrikaans in this context, is the language of insider identity and familiarity and it is often the language used to surreptitiously challenge the system.[6] I explore this further in the section on carnival.

"Inside\outside", "them and us", are themes which extend across many layers and groups. There are the nurses who view themselves as outside, yet feel that because of their race or cultural identity they can identify with patients, particularly the elderly, and there are the patients who are positioned on the outside yet often feel they are part of the inside. This analysis calls into question a dichotomized view of them and us, inside and outside. Instead, I argue that subjectivity is in process, is unstable and embodies diverse and sometimes contradictory subject positions.[7]

> Subjectivity can be read as multiple, layered and non unitary; rather than being constituted in a unified and integrated ego, the 'self' is seen as being, constituted out of and by difference and remains contradictory(Aronowitz and Giroux,1991:76).

Because there are inconsistencies and contradictions between and within discourses, subjectivity is not a single uncontested entity but is fluid and shifts over time. This is evident in the changing and contradictory discursive positions adopted by patients and staff.

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[6] However, in other socio-political contexts, Afrikaans has been viewed as the language of the oppressors or previous regime.

[7] I am influenced by the postmodernist re-theorizing of subjectivity.

The following spatial stories are presented through the voice of a staff member and a patient informant. Even though their hierarchical position presupposes difference, they express similar sentiments. The main focus is on a closed, stable community with repeated references to a "Golden Past".

Sr. G states, that as she "sees it, the culture of the community has changed". She engages in a discussion concerning the importance of traditional folk practices which were part of the "old culture". Her narrative is infused with moments of nostalgia and an appeal to more traditional forms of medicine and value systems. Yet her appeal is not solely an entreaty to the past but a concern with the present misuse of modern medicines which form part of the culture of entitlement.

> The more traditional older Coloured people had many of their own remedies. You see we had a lot of our own simpler and less expensive medicines. These were good for minor ailments and far better than always depending on antibiotics. There has been a definite break down of the culture. The disintegration of the community's culture is evident in teenage pregnancy, sexual promiscuity, multiple sex partners, alcoholism and drugs. [8] Even though people do not like to hear this, a lot of the teenage pregnancies and other social problems can be attributed to the apartheid system whereby school provision for the community was only until Standard Five and so out of boredom, frustration and low self esteem young women had babies. Having a baby was a form of being able to possess something of their very own, like owning a doll. In the first year they look after the baby and dress them in fancy clothes but as the children get bigger and become active toddlers they soon get bored and feel trapped and that is when we see problems. For the first one to one and a half years the children are healthy and well dressed. Once the child becomes more active they tend to display evidence of neglect such as frequent colds, runny noses and viral infections. Patients need to revert back to more traditional herbal and folk remedies that were found in the community. For example, Scott's emulsion, [9] mint tea, camphor cream and garlic worn around the neck.(I notice that she occasionally writes the words Scott's emulsion on a piece of paper and hands it to some of the mothers).The younger generation expect modern Western medicines like antibiotics, cough medicines and various other medicines for minor illnesses. They expect to receive at least two to three medicines with each

[8] Similar sentiments are reflected in her Community Profile of 1994.
[9] Scott's emulsion is a vitamin and mineral supplement available at supermarkets and pharmacies.

> visit. They become dissatisfied with the service if they do not receive an adequate amount of medications. My standing in the community is dependent on the number and variety of medications that I dispense. I would not be considered a good nursing Sister if the patients did not leave the clinic with at least two to three medicines. The older people adhere strictly to their old values and norms. The younger generation are putting their values and norms aside due to the influence of television and the changing trends of society.

The notion of a closed and insular community is further reflected in her comments :

> People have their own way of life, very few people venture out. They inter-marry and stay in the fishing village (Community Profile, 1994.5).

Ironically, Sister G who exemplifies allopathic medicine promotes more traditional practices which are disappearing due to the influences of modernization. But her appeal or bid for "more traditional herbal and folk remedies" is not solely a plea to a golden past but can be located in the concerns for inappropriate use of medications and unrealistic expectations and demands by patients, what is repeatedly referred to as the "culture of entitlement, and expecting things for free". A voluntary social worker asserts:

> We have spoilt them rotten, now they are used to getting everything for free.

In Chapter Two I commented on the prevailing super bug poster which alludes to similar sentiments.

Through the grand narrative of apartheid that contrasts the past to the present an attempt is made to draw a definable historical agent.[10] Sister G's narrative is a veiled social and moral discourse on the deteriorating conditions of the community which is plagued by crime, violence and alcohol and drug abuse. One gets the sense that Sr. G is attempting to mediate between the present realities and the past with little recognition that present conditions can not solely be attributed to the legacy of

[10] Teenage pregnancy, inferior education and other social problems are ultimately attributed to apartheid.

apartheid. What is missing in her explanation is that these "social problems" are developing processes and not fixed in time.

Allusions to close associations between families and neighbours and between hospital staff is a theme I hear repeatedly. This vignette is illustrative of community identity. The narrator draws an analogy between the hospital and her home.

> I have been visiting this hospital for a long time now. I know most of the staff. My husband is away at sea for long periods of time, as he is a fisherman. Most of the men here are also fishermen. I live in one of those gray flats just nearby against the hill. I don't go out much, just to the hospital or shops or to visit friends. Some of my friends have video machines as there is no nearby bioscope. The young people might go to Wynberg, but most of the older people stay at home and watch videos at each other's homes. I also go to my friend who has a video machine as I don't have one. I like those action films. We are all like a family. This community is like my family, there is always someone to visit or talk to. No Miss, I won't move out of this area. Now there is no more apartheid, so nobody can move us. It's so friendly here and we *mos* [11]help each other out, and so is this hospital. This is like my home because I know everyone, even all the staff. I would not like to visit one of the other hospitals because they are unfriendly there.

At a later stage she provides a description of how Africans were moved from the area near the harbour mouth to Mandela Park.[12] A form of spatial segregation exists in the waiting room. The black Xhosa- speaking patients from Mandela Park sit on one side of the room, whilst patients from the harbour area sit on the other side. I note little interaction between the Xhosa-speaking patients and the patients from the harbour community. I ask one of the patients why this is so.

> You see we don't really know these people and they speak a different language to us.

It is significant that the informant in this instance distinguishes difference in linguistic terms and not on racial grounds.

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[11] "Mos" can be translated to "kind of ".

[12] The area near Mandela Park and Imizamo Yethu squatter camp has its own clinic. The patients attending this clinic are mainly Xhosa-speaking.

Further references to a golden past can be found in the narratives of two elderly women residing in Hout Bay. I recently had the opportunity to read transcripts of taped interviews undertaken by the curator of the Hout Bay museum. Extracts from the following interviews form part of a series of interviews on the life histories of local families currently living in Hout Bay. These interviews were conducted between 1992-1993 by the curator of the Hout Bay museum.

The nostalgia about the past is present in the narrative recounted by Joan, a member of the Cairns family, who still lives in Hout Bay. The Cairns family have been resident in Hout Bay since 1921. The entire family originally lived in a large house next to St. Peter's Church, the latter played a key role in the religious and educational lives of the Coloured residents.[13] This house exists today and is situated behind Passageways a small shopping centre in Hout Bay village. The house was a favourite meeting place for members of the community. The narrator recalls Sundays as joyous occasions:

> We really enjoyed our Sundays. Every Sunday when my mother cooked the food she would put her cakes in the oven. We had what looked like a tearoom on a Sunday afternoon- the place was full of people from Wynberg or Claremont who used to come and visit. As they left my father would give them one of his beautiful ferns or plants that we had.... I must say we had marvelous times there (Extract from Chapman's Chaunce, Edition No.18, 1994:4).

Joan elaborates further, describing how young people would gather in the evenings in their home to sing and play the guitar. She proudly recounts how her mother, an excellent seamstress, sold items of clothing to prestigious department stores in the city.

[13] As early as 1920, St. Peter's church established a school for the Coloured children of the community.

The family was subsequently moved from their house in the village, to the cottages in the harbour.[14]

> They were excited and pleased with their newly built houses, as the most exciting part was the fact that they had electricity (Chapman's Chaunce Edition No.18, 1994:6).

Similarly, Minnie, who in 1966 moved to her present house in the harbour states:

> *Ek was bly toe ek hier gekom het, na die hawe, want ek het net soos 'n hond gewoon. Ek moet die heeldag werk en dan 'n plek gaan soek vir my kinders. Daar was nie baie huise nie. Plekke was maar skaars, nie soos nou nie. My man was 'n visserman. Partykeer was die vis volop, anders was daar amper niks vis, net soos dit is vandag. Maar daar was meer vis in die ou dae* (Interview with Minnie Moses, February, 1992:2).

> I was happy when I came here, to the harbour, because I lived just like a dog. I had to work the whole day and then go and look for a place for my children. There were not many houses. Places were scarce, not like now. My husband was a fisherman. Sometimes the fish was plentiful, otherwise there was almost no fish, just like it is today. But there was more fish in the old days (Interview with Minnie Moses, February, 1992:2).

Both these narratives reflect a strong sense of a romanticized past. It is interesting to note that both these women state that they were happy to move to the harbour area. There are continuities between these narratives and Sister G's preceding narrative. The day hospital can be depicted as **paradoxical space**. A space of contesting literacies and a place in which members of the community have displaced the boundaries between the formal and informal. Yet, this is a space that correspondingly maintains its own rituals and boundaries demarcating it from everyday space, as a space of support and medical treatment and authority. A space where members of this community have access to, and receive medical and social resources. Within this dynamic Lefebvre has argued :

> Visible boundaries such as walls or enclosures give rise to an appearance or separation between spaces where in fact what exists is an **ambiguous continuity** (1991:87) (emphasis is mine).

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14 These cottages were built for the fishermen who worked in the fishing factories and on the fishing boats.

In Chapter Two I described the induction process into the medical institution and the way in which the patient is bureaucratically constructed and read as an institutional text within the institution. The manner in which these normalizing procedures serve to remove patients from their pre-institutional identity or sense of personhood. However, this process is neither uniform nor uncontested, patients are through their own socially embedded literacy practices able to re-appropriate medical discourse and use these literacies as a vehicle for demanding services and entitlements. Space is transcribed into paradoxical space because alongside these asymmetrical relationships are instances of resistance and contestation; formal official space versus community space. The code switching of languages (English versus Afrikaans) is often a recognition of these asymmetrical relationships. Reclamation of the hospital space as community space by patients' resistance practices and social interactions is reflected in the concepts of carnival, the culture of entitlement and working the system.

3.5 Carnival: Crossing the border

I draw on Bahktin's(1968) descriptions of carnival described in "Rabelais and his world" as it captures the essence of what I observed in various spaces allocated to patients. The sense of festive activity can be considered analogous to carnival. Anthropologists have examined carnivals and festivals as meta-commentaries on everyday life. For example, Geertz's(1973) thick description of the Balinese cockfight and Stewart's (1986) socio- political analysis of carnival in Trinidad. I draw upon my observations reflected in my fieldnotes.

> My initial impression is one of general pandemonium. The waiting room is a hub of social activity and is filled with patients of all ages, ranging from the very young to the elderly. Some are sleeping across benches, whilst others are wandering in and out. Children run in and out, eating ice lollies which are dripping onto the floor. A group of children are playing with a cat in a go-cart. An elderly patient avoids falling over a boy on his skateboard. Many of the mothers appear oblivious to the fact that their children are running amongst the cars in the parking lot. A mother runs outside in search of her missing toddler. There is a general sense of chaos and abandon, reminiscent of Bahktin's depictions of carnival. Amidst the raucous laughter and general fanfare is the authoritative voice of the nurse calling patients to order. The formal and informal are fused detracting

from the notion that this is a space reserved for illness and dis-ease (Fieldnotes, 19/9/95).

Bakhtin's portrayal of carnival can be viewed as an examination of popular culture during the Renaissance. Carnival is Bakhtin's term for:

> a bewildering constellation of rituals, games, symbols and various carnal excesses which together constitute an alternative 'social space' of freedom, abundance and equality (Gardiner, 1992: 45).

Carnivals were often the few cultural spaces that evaded the direct control of authority, allowing for a temporary sense of freedom and disorder. These concepts are important as the social activities observed in the spaces allocated to patients were often symbolic of carnival. Institutionalized rules of social conduct were temporarily suspended and replaced with lively social interaction.

The popular speech genres of carnival, folk laughter and market place speech, often express a distinctive ideological viewpoint which is opposed to the world of officialdom. Colloquialism and profanities were for Bakhtin a codified form of verbal protest, and a challenge to the monologic voice of the institution.

A patient in the outside space voices his dissatisfaction and informs a friend not to accept reductions in the number of medicines dispensed. He uses expletive language and yells at a passer-by. [15]

> *Ek sê vir jou, hierdie plek is nou vol bullshit. Hulle gee nou min medicines.*
> I am telling you, this place is full of bullshit. They really give very little medicine.

He addresses me and elaborates:

> *Ekskuus Mevrou, maar dis onregverdig, dis 'n hele klomp nonsens.*
> Excuse me Madam, but it is unfair, it's a whole lot of nonsense.

I meet a patient attending the psychiatric clinic who complains that after nine years of "being satisfied on the injection for her nerves" she is now receiving tablets which are

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[15] This patients hurls his insults in Afrikaans. Later he speaks to me in English. He code- switches between Afrikaans and English. This is a further example of the relationship between language and social identity.

causing her problems. She is visibly distressed and complains of feeling cold and lame due to alterations in her medication regimen.

> Miss, that injection was very strong and good. I mean, this is difficult for me now. Those tablets are no good because they make me lame. This is not right.

The latter complaint might not be as vivid as the previous narrator's. In a more discreet manner, she voices her dissatisfaction with the changes that she experiences and is able to challenge, in an indirect way the authoritarian attitude of the medical staff.

Just as carnival, with its rituals and practices, was a form of resistance against the existing social order, so too is the carnivalesque atmosphere manifested in the waiting room and corridors, a form of self expression and resistance. In this setting (institutional space), carnival can be viewed as symbolic of communal performance, identity and discursive struggle. Through the different speech genres; laughter, silence, profanities and the appropriation of unofficial discourse, patients are able to express or say something.

> Carnival brings together, unifies, weds, and combines the sacred with the profane, the lofty with the low, the great with the insignificant, the wise with the stupid (Gardiner,1992:123).

In a further incident, two women through their dialogical interactions (parody and disrespect) and in their use of different linguistic and communicative codes manage to informalize formal, institutional space.

> I notice two young women standing outside the Family Planning clinic. They are ridiculing an older Xhosa-speaking nurse who appears to have a problem pronouncing their names. [16] They answer her questions in Afrikaans, parodying her English amidst peals of laughter. They insist on replying in Afrikaans, despite the fact that she addresses them in English. A few minutes later they address me in English. There is a display of bravado but when a "Coloured" nurse addresses them, they are less bold and change to a politer

[16] I was informed that the nurse was from the clinic near Mandela Park squatter camp and that she was "helping out" for the afternoon.

> mode of discourse. They are repeatedly instructed to lower their voices but nobody appears to take any notice.

Space in this instance is narrated and recontextualised as informal space, a space which is distanced from the medical gaze. The authoritative voice of the nurse, as she attempts to restore order, gives way to a plurality of independent and unmerged voices. There is a sense of momentary disorder which is a threat to the monologic voice of the medical institution.

If one views the body as a system of social representation then the manner in which the exterior of the body is presented can also signify or symbolize in space. **Dress** is discursively constructed. I note a particular genre of dress style in the form of clothing and hairstyle.

The type of dress worn by a group of women attending the Family Planning clinic is at times symbolic of carnival. It is not only dress style but also demeanour, body comportment and body language. The dress and associated conduct of the women seems out of place in the hospital setting with its attempts at order, discipline and normalization but it is the manner in which the women are able to maintain their own sense of individuality and personhood, a challenge to the monologic voice or normalizing rules of the institution. Furthermore it is a subtle transgression of institutionalized rules, conduct and dress code which regulate the type of behaviour and attire within an institutional setting.

Extracts from my fieldnotes further support my argument. Dress, in this instance, is about how these women represent themselves in social space. It is an individual and collective expression of who they are.

> It is a hot day and many of the women appear dressed for a visit to the beach. Most of the women have adornments in their hair such as curlers and intricate braids. The younger women arrive in short skirts, midriffs, shorts or tight pants, whilst some of the older women from the nearby fishing factory wear overalls, gumboots and headscarfs. A woman with curlers in her hair smiles, revealing teeth embellished with gold stars and says: "*Ek gaan vanaand uit, dis hoekom ek my curlers dra.*". "I am going out tonight, that is why I am

> wearing my curlers". In contrast I note that the staff adhere to a dress code and wear a uniform with epaulettes on their shoulders not too dissimilar to military uniform (Fieldnotes, 19/9/95).

Shilling (1993), has argued that the body in high or late modernity[17] has become increasingly central to the modern person's sense of self identity. The body as portrayed in the media through television, videos, advertisements and magazines leads to the modern persons' concern with the maintenance, management and appearance of their body. One can argue that the women visiting the Family Planning clinic are similarly concerned with their bodily self- image as expressed through their dress. Their bodies become the bearer of symbolic value discussed further in Chapter Four. However, one can argue that these women constitute the underclass of SA society and are situated on the margins of the wider socio-economic structures, thus to translate their everyday life experiences in Eurocentric terms of high modernity could on first reading appear problematic. I would argue that trans-cultural and trans-national relations have however penetrated their daily life experiences and that they are exposed to the media through television and videos and are thus influenced by high modernity's concerns with bodily self image.

The following vignette further demonstrates the manner in which formal space is translated into informal community space, through the actions of three schoolgirls who "hang about" in the outside space. The outside space,(the parking lot and steps to the hospital entrance) where people gather to exchange news and smoke, is similar to Goffman's(1961) depictions of "free spaces". Free spaces are areas distanced from the direct surveillance of staff.

> I meet three schoolgirls who are sitting and smoking in the outside space. I join them. They are silent at first, but soon continue to talk amongst themselves. The older of the three announces that she has a sore finger. Later Sister A informs me: "These girls often come to the hospital as an excuse to get out of class. There is nothing really wrong with them". I notice them laughing at a young girl of fourteen, who is lifting her skirt, exposing her underwear. I am disturbed by the cruelty displayed towards this young girl who appears oblivious to the fact that she is transgressing social norms by

[17] The term high modernity has been used by Giddens(1990) to describe the radicalization of modernity in the late twentieth century.

exposing her underclothes. Chantel giggles: "*Sy is nie lekker daar* (pointing to her head). *Sy dop die hele tyd by die skool. Sy was in die aanpassingsklas, maar sy moet haar Ma gaan help.*" [18] She was an object of ridicule. I then asked whether I could interview them. Dialogue was fragmented by frequent interruptions, yelling to friends passing by on the street and constant chatter amongst themselves.

The polyphony of shouting, laughter and bravado creates further space for carnival. Choosing the hospital as a place in which to play truant, sleeping or lying across benches, playing loud music, skate boarding on the periphery of the waiting room and in the hospital grounds, the joking and profanities when I ask about condom use, a burglary and finally the intrusion by two known "*skollies*"[19] armed with knives in search of a gang member are all violations of the rules and norms of formal institutional space, of **crossing the border.**

The concept of carnival allows for seepage and permeability between and within social spaces and illustrates the manner in which patients and community members have displaced and transgressed the boundaries between formal institutionalized space and informal community space. By bringing the community into this space, they have transcended and popularized formal space. Through periods of carnival, patients are able to resist the dominant social order. Another way of viewing the situation is that the day hospital, as institution, has not managed to 'colonize' a space for itself within the local community.

3.6 Working the system

The manner in which place is appropriated and negotiated to create space are reflected in the negotiation for personal standing and recognition between individuals within the system. Both engender a sense of autonomy in the face of institutional

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[18] She isn't happy there. She keeps on failing at school. She was in the remedial class, but has to go and help her mother. In transcribing this text the local vernacular is not easily translated.

[19] "gang members". There are two known gangs in the area, which according to Sister G have the occasional "flare up".

power. Whilst the former create a space of safety, the latter may have the added benefit of securing material or psychological gain.

Goffman's(1961) analysis of hospital underlife in a mental institution introduces the term, working the system.

> The exploitation of a whole routine of official activity for private ends, I shall call working the system..... In order to work a system effectively one must have an intimate knowledge of it (1961:189-191).

Health and welfare entitlements are frequently a routine element and an important component in patients' everyday life practices. I draw parallels between Goffman's descriptions of "making out" in the institution and the manner in which many patients appear to 'work the system.'

'Working the system' is an attempt to rescript and recontextualize the dominant into local terms. It concerns the way in which patients respond to expert knowledge systems within their own social environment and how it is recontextualised from one form of literacy to another and how these literacies are translated, taking on their own social meaning and values. Often a symbiotic relationship is formed, patients are dependent on the system for entitlements and have to adhere to certain rules, yet on the other hand, through their intimate knowledge of the system and close relationship to it they are able to negotiate and mediate their position within the institution.[20]

> In considering the process of "working the system", one must inevitably consider the ways in which hospitalization itself was worked. For example, both the staff and inmates sometimes claimed that some patients came into the hospital to dodge family and work responsibilities, or to obtain free some major medical and dental work, or to avoid a criminal charge (Goffman,1961:194).

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[20] Weinstein-Shr's (1993) study of literacy and social process amongst Hmong refugees in Philadelphia explores the way in which individuals use literacy as a tool for negotiating with new institutions. This can be viewed as another example of working the system.

Jim, aged thirty is a "regular" visitor to the clinic. He volunteers to be interviewed and returns throughout the morning to complete the interview. He asks me whether I am a social worker. He still calls me "Sister" despite my explanations. Occasionally he uses the term Mevrou.[21] He informs me that he works on his brother's fishing boat but is now "off work" as the fishing season has ended.

> "It is very important to look after one self. *Mevrou, ek voel tevrede met myself.*(Madam, I feel satisfied with myself). The other patients are *siekerig en praat deurmekaar* (sickly and talk in a jumbled fashion). I am here to see the psychiatrist because I have a *geestelike siekte* (mental illness)." I appear puzzled. He switches to English, and clarifies: "you know, schizophrenia". He flags me down as I am driving out of the hospital and asks me to help him with a form. "It's my disability form, I need some help because it is in Afrikaans". I am perplexed, Afrikaans is the language that we had communicated in. I notice that the form is in English on the reverse side. After much deliberation, I realize that his disability grant is only due in six months time. "I cannot wait that long. I am not happy with the situation. How must a person get along? It is too long to wait. Maybe my brother can help me with the Afrikaans, but nobody is able to help me with the English. Earlier you asked me the name of my injection, I now remember the name of my injection, it is clopixol."

I later discover that to be eligible for a disability grant, Jim needs to attend the psychiatric clinic on a regular basis for a minimum of six months. I subsequently realize that Jim must have been aware of my confusion but was at pains not to correct me. He was mediating between what he thought was my hesitancy and my scant knowledge of the inner workings of the welfare system. By enlisting sympathy and by helping him fill in his form I could perhaps convince the medical staff of his consistency and compliance. I could, as representative of authority, whether medical or welfare, mediate on his behalf. As potential literacy mediator I was suited to this position not solely on the grounds of my ability to decode texts but rather my social

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[21] Translated into English, Mevrou means Mrs. However, in this context it denotes a sign of deference and not necessarily an indication of marital status. Most female informants use the term Miss, yet most of the men use the term *Mevrou* as a sign of distance. I have chosen instead to translate *Mevrou* to Madam as it further reflects racial and gender subtexts.

position within the system. I could as a nurse or social worker provide a certain amount of credibility to his unfortunate situation.

The juxtaposition within the same speech exchange between two different language systems is an example of an attempt to rescript dominant discourse monopolies. Jim has acquired a certain level of medical literacy and is eager to display his knowledge. He code switches between "*geestelike siekte*" and "schizophrenia" and returns to inform me of the name of his injection. He masters medical discourse in both languages. Despite his command of medicalized discourse he is divested of power and experiences difficulties in accessing welfare entitlements.

A discussion with the psychiatric nurse further supports my argument. She is aware of Jim's ability to work the system. Jim is constructed as someone with a history of poor compliance, and for his own mental well- being, is required to return timeously for treatment. The complex interplay between Jim's desire to obtain his disability grant and the dominant discourses' attempts to monitor access to entitlements is a further example in which literacies are recontextualized, taking on unintended social meanings and values.

> I know Jim well. He is on a monthly injection for his schizophrenia. He often forgets to come or keep his monthly appointments. That can be a real problem because he has already ended up at Valkenberg.[22] This is often a problem, as you know, because patients do not return for their treatment and when it is a chronic long-standing problem and the medicine controls their mental state it becomes important that they show a sense of responsibility. He is fine now but if he is not on his medication he can easily have a relapse. It is hard to keep an eye on all these patients. We have already seen fifty patients this morning. It's far too many in such a short time. I am hoping for more assistance soon. The patient's problems are not only psychiatric but are also about social and life style issues. Many of the patients really come here to talk and want us to listen to their social problems. We are often just like social workers.

Patients' problems are characterized as being largely attributed to "social and life style issues". This is a recurrent theme throughout and something that all the nursing staff have referred to. They identify their nursing practice as being related to "social

[22] Valkenberg is a psychiatric institution in Cape Town.

problems and life style issues", yet little has been proposed to address these problems apart from a desire for larger and more modern facilities and efforts to provide further education. There is an incipient recognition of the wider social problems but the nursing staff feel disempowered, echoed in statements such as: "The staff- patient ratio is far too high to be able to provide individualized care and to have time to provide education."

The following, concluding narrative raises the question of how narratives regulate particular forms of moral and social experience and how through a powerful oral performance, the narrator is able to enact her experiences of institutionalized medical literacy. It is a vivid example of how two parallel literacies can be skillfully played alongside each other. The play of the opposing forces that this woman experiences, mirrors the play in the institutional and community forces in their efforts to find balance and accommodation in the appropriation of space. She has chosen this particular space to enact her narrative. This is not a chance event, rather it is a well-rehearsed performance narrative.

The interview was conducted in English. The informant spoke fluently throughout and I found it difficult to accept that she was or had been a "heavy drinker". She was self-assured, articulate and never faltered, nor was she distracted by the noise and frequent interruptions. The tenacity with which she recounted her story could not be overlooked. I was perplexed by her story and subsequently consulted medical reference books to gain more insight into fetal alcohol syndrome.[23] Perhaps impaired fetal development could be attributed to an isolated episode of excessive alcohol consumption? In my search for clarity I asked the nursing staff whether they knew the informant. They confirmed that she had a chronic alcohol problem.

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[23] Fetal alcohol syndrome occurs when the baby in utero is physically and mentally affected by the mother's heavy and regular drinking of alcohol during pregnancy. Cases of fetal alcohol syndrome have occurred only in children of severely alcoholic mothers who continue to drink heavily(80 mls of absolute alcohol per day) throughout their pregnancy. (Harrison's Principles of Internal Medicine, 1983:1293).

I meet a young mother who is concerned about her daughter's high temperature and facial swelling. This initiates a discussion about her child's medical problems. I examine the swelling and offer medical advice. The mother asks: "Are you also a Nursing Sister?". I respond by informing her of my position as a researcher and as a nurse. I mention this as it relates to the manner in which she constructs her ensuing narrative.

"The reason why I brought my child here is that she is a fetal alcohol syndrome baby, and I am concerned about this swelling. I can't take any chances. You see, she is a fetal alcohol baby, mentally retarded and also a milk allergy child." I ask whether she is an alcoholic.[24]
She replies : "No I weren't an alcoholic. I only went to one single party where I had some spirits, not knowing that I was expecting. I am a social drinker and only had one drink. I suspected that I was pregnant and knew I was going to a party so I went to the doctor and told him my concerns and he said: No Mommy, everything is OK you are not pregnant. I went to the doctor the following month with the same concerns and I told the doctor that I just want to be sure. He shouted at me saying, I am the doctor and I should know. I then said fine, I am going to the party. I then went to the party and had some spirits. I then discovered that I was pregnant, but this was long after I went to that party. I said to that same doctor, why did you not tell me? He said : because I did not know. After the birth I just felt that the baby was not right and she wasn't picking up. [25] I even received notices from the Social Welfare Department stating that the baby wasn't picking up. I was concerned that if

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[24] I ask her whether she is an alcoholic, this is in response to her openness about her child's mental retardation due to alcohol abuse. In hindsight, I realize that this is culturally insensitive. I have employed inappropriate medicalized discourse, discourse pertinent to a client -counsellor situation in a drug or alcohol rehabilitation centre. The narrative continued despite my initial blunder.
Alcohol abuse amongst the Coloured community in the Cape Peninsula has been well documented and the subject of extensive research. Its history has been linked to the "tot system" whereby farm labourers were given reject wine in lieu of, or in addition to pay. This system can be traced back to the early nineteenth and twentieth century and persists to this day on some farms in the Western Cape. There were numerous references by nursing staff that many patients had "alcohol or drinking problems", this was further documented in the Community Profile of 1994. Similarly, Breier(1994) refers to instances of fetal alcohol syndrome and consequent mental retardation in Ocean View, an area in close proximity to Hout Bay.

[25] " Picking up", is the local vernacular for gaining weight.

she did not pick up after a week, they would take the child away. I then went to see the doctor again and after much talk between the other doctors and medical staff, he said : Mommy, your child is a fetal alcohol baby. It was a big shock knowing that I am not an alcoholic. How do you prove, that you are not an alcoholic? I was then referred to the pediatrician at Red Cross Children's Hospital. That doctor could not say it to my face, he wrote it in a letter addressed to the doctor at Red Cross Hospital. When I got home I had to know what it said. I have to know what is going on. I steamed some water and opened the letter. I was quite shocked. I was terribly upset. The letter said: This mother denies drinking alcohol during pregnancy. I was quite furious with myself and also the doctor as I ought to know what is going on. Whatever it is, I have to face it, even if it takes ten to fifteen years. I have to face it and live with it. Then I phoned the doctor and told him it was very unfair not to tell me this, and to write that letter and not informing me. I mean, I have to cope with this. I said to him, you should have told me. The guilt is on me and I have to live with this for the rest of my life. Then a doctor from Red Cross who is like a good friend sat me down and talked to me and said don't upset yourself, you made this mistake it's not your fault. Here, the doctor is to be blamed. He could not do his work properly. You went to him first, and from there we have lived with it."
Me: "You seem to have handled the situation well"
"Yes I did, even though I failed Standard Eight and I never went back to school. Today I regret not going back to school."
Me: "Really, why is that ?"
"Because if you look at the world and you look at your friends, there is so much in stock for yourself."
Me: "Do you get any support from your children's father?"
"Literally no, but now it is working out. Hopefully he will support us. I was working before now. Then I have also got my friends from the church who help me."

The complex interplay of events surrounding this narrative is fraught with contradictions and inconsistencies. Rosaldo(1986) in his study of Ilongot hunters argues that self reflexivity can be an important component of narratives. Thus the stories that hunters recount are the stories they tell themselves about themselves.

> The stories these Ilongot men tell themselves about themselves both reflect what actually happened and define the kinds of experiences they seek out in future hunts. Ilongot huntsmen experience themselves as the main characters in their own stories (1986:134).

I base my analysis on the events that this woman was able to narrate and reflect on, and not necessarily on the event itself. It is against this background that I examine what is essentially a symbolic performance practice constituted within the

institutional space of the day hospital. She constructs her experience in a diverse manner and chooses this particular space to enact her narrative. She has chosen to recount her story to me as a potentially sympathetic agent of the medical establishment.

The contesting literacy practices(medical \official versus local), are her attempts to challenge and discredit the medical institution through their purported mismanagement during her pregnancy. By reappropriating medical discourse and in her comprehension of certain medical texts, she is able to turn the medical gaze back onto itself with allegations of mismanagement. By redirecting her blame back onto the medical experts, or towards an 'other' she is able to enact her own shame. The fact that she is able to decode hidden texts (in the form of the letter that she steamed open) and thus access secret knowledge is significant. By utilizing her own social literacy practices she is able to challenge and contest the dominant medical literacies.

Through her narrative and use of formal[26] and local registers[27] she is able to bridge the divide between the medical world and her own social world. Subtexts of race, class and gender reflect the communicative and linguistic codes that she employs throughout the interview, and in her communications with the staff. She converses in English with me and with the doctor.[28] In my presence she speaks to the nurses in English, despite the fact that they address her in Afrikaans. However, I subsequently overhear her conversing in the local vernacular with patients and with the Coloured nursing staff. She code switches as the situation demands, switching to formal Afrikaans when appealing for urgent medical care for her daughter. Her fluency in both languages and in different linguistic codes affords a certain amount of status. Speaking English provides a brief moment of identity transformation. The hierarchical difference between English and Afrikaans symbolizes the hierarchy between medical literacy and medical "illiteracy". She attempts to claim ownership

[26] The use of medical terminology such as, "fetal alcohol syndrome baby", and "milk allergy child".

[27] The more colloquial discourse of "picking up".

[28] Both are white females.

over medical literacy by speaking English with the experts. She has come to realize that expert knowledge systems are secret knowledge systems, and that secret knowledge systems exercise concrete power over her life. Furthermore, these systems are dependent on stratified communication channels, that she attempts to destratify. However, despite her English literacy, she remains divested of discursive power. Expert knowledge discourse dispossesses her at several real and imagined levels.

One can further argue that this narrative contains elements of a rehearsed performance practice. It is a way for a mother suffering from guilt and shame to work through some of her pain. Echoed in such phrases as:

> I mean, I must live with it, even if it takes ten to fifteen years.

But who gets to name blame? Is she authoring her own narrative around issues of alcohol abuse and associated child neglect? Through her narrative she makes a move towards rationalization, aligning herself with, on the one hand the structures of morality, (her denial of alcohol abuse and her association with the church), and on the other hand, aligning herself with certain members of the medical establishment (the doctor who is a good friend). She presents, through rationalizing her "guilt" and shame, an elaborate story of her innocence, redirecting and transferring the "blame" onto the medical institution. Through her reappropriation of medical discourse and suggestions of negligence, she is able to turn the medical gaze back onto itself.

Goffman (1961) describes how patients in the mental hospital environment, in order to normalize their status as mentally ill or avoid humiliation, create "self supporting narratives" proving that they are not sick, and that their "little trouble" is really somebody else's fault. These stories are what Goffman refers to as "reciprocally sustained fictions". The day hospital is a safe place, a space in which a distraught mother is able to enact her own self supporting narrative. It is in this space that she is able to redirect discordant feelings of guilt and shame towards the medical establishment. Through her narrative, negligence is leveled at the medical establishment, through the voice of one of its agents, an empathetic doctor. This is

contrasted against the paternalistic and dogmatic manner of another doctor, in the voice of, "Mommy, everything is OK", to "I am the doctor and I should know". In isolating the 'negligent' actions of one doctor, she is able to avoid discrediting the entire medical institution. Her support of the medical establishment is further endorsed through utterances such as: "Doctor B is a nice lady" and " The guilt is on me".

She provides a certain amount of closure to her tale. Through her own narrative she is able to alter the reality of her situation by juxtaposing these seemingly contradictory subject positions. On the one hand, she is dependent on the system for medical treatment and entitlements for her sick child, yet on the other hand, through her performative narrative she is able to voice her dissatisfaction and enlist sympathy from sanctioned medical staff thus still maintaining her position within the system. She is thus able to gauge permissible practice within the confines of the system.

3.7 Conclusions

Through the narratives recounted by staff and patients I have shown how spatial dichotomies of inside and outside, formal and informal, have merged to form in certain instances integrated community space. The boundaries between formal institutional space and informal community space are reconstructed resulting in a process of hybridization. The manner in which space is inscribed, read and narrated by patients reflects a complex process of attempting to recontextualize and rescript manifold medical literacies as it relates to their everyday life experiences and practices.

In writing this chapter, literacy practices appeared elusive in the events that I had encountered so long as I leaned towards the autonomous model of literacy. I had to keep in mind that there are different ways of "seeing" literacy, that literacy is a relative construct. The hidden texts in all of this was that patients and staff were rescripting or recontextualizing their experiences of medical literacy and technology in order to create an environment more integrated and suited to their daily realities.

The reconceptualization of literacy as embedded in social practice enhanced by a spatial analysis allowed for a detailed exploration of the way in which literacy practices are embedded in institutions, settings or domains. These in turn are implicated in other wider socio-political, economic and cultural processes (Grillo,1989).

The violation of rules[29] and the manner in which space is appropriated by members of this community is a response to a dominant discourse monopoly. It has the effect of refashioning formal institutional space into communal space. Whilst patients may not directly engage with medical texts, they have reorganized and transcribed their experiences of medical objectification into their own social order and through hybridization have created their own space. Out of place they have created space. A space of softened institutionalized borders, a space of familiarity, family, comfort and home.

[29] Carnival is one instance of violating certain rules.

CHAPTER FOUR
BODY LITERACY AND BODY SYMBOLISM

4.1 Introduction : Mapping the conceptual terrain

In this chapter I extend the exploration of ways of 'seeing literacy', more specifically those which include practices or techniques of inscription on the human body. The move towards body or somatic literacy enabled me to uncover hidden literacy practices, (those not strictly alphabetic) and to thereby understand dissonances and disjunctures that had previously appeared incomprehensible.

My aim in presenting the following theoretical perspective is to foreground the data obtained in the field site and to further explore ways of 'seeing literacy' through notions of the textualized and symbolic body in which the body is viewed as an open signifier and bearer of symbolic meaning. The body is thus conceptualized as a semiotic medium or cultural text which is inscribed and made meaningful through the operation of contesting signifying practices.

Academic scholarship[1] has recently afforded centrality to the study of the body as a separate entity and the importance of a theoretical understanding of the body to social and cultural analyses of contemporary societies. Most writings about the body in social theory have been influenced by the writings of Michel Foucault, who introduces reference to the body as a **text**. I was informed by his analytic concepts and 'history of ideas', principally as they relate to the concept of the disciplined and regulated body under the 'medical gaze'.
Shilling, who characterizes Foucault's approach to the body as "socially constructed" asserts :

> The Foucauldian approach to the body is characterized, first, by a substantive preoccupation with the body and those institutions which govern the body and

[1] Shilling(1993) provides a comprehensive study of human embodiment and the new directions taken in the 'sociology of the body'. My focus on Foucault is not intended to preclude other academic scholarship on human embodiment.

> second by an epistemological view of the body as produced by and existing in discourse (1993:75).
>
> The importance of the body to Foucault is such that he has described his work as constituting a 'history of bodies' and the manner in which what is most material and most vital in them has been invested (Foucault, 1981, in Shilling, 1993:75).

The work of Foucault(1970;1972;1979) has brought the question of the discipline of the body and the rise of scientific knowledge to the centre of theories on the body and medical histories. Foucault(1979) traces the genealogy of discipline from public visible torture and punishment to invisible techniques of surveillance and control. While it is difficult to summarize Foucault's vast works, nor is it the focus of this thesis, one central theme of his treatment of knowledge and power is that the growth of organized knowledge coincides with the extension and exercise of social control over **bodies** in social space. This theme can be illustrated by his study of the development of penology and criminology which facilitated a more rigorous control of the criminal body within the scientifically managed social space of the penitentiary.

Bentham's panopticon scheme provided a systematic control of surveillance of the inmate world and established a model of docility for schools, factories and hospitals. Through its architectural structuring (a central watchtower) the panopticon provided constant surveillance and control over bodies, not through overt violence, but through a micro-politics of discipline.

While the concept of the panopticon needs to be modified in the context of the day hospital it can be argued that the spatial structuring of the reception area, waiting room and dispensary facilitate a form of surveillance, an observant monitoring of patients' activities within the medical space, a micro -politics of discipline.

Foucault's concepts of the disciplined and morally regulated body and technologies of inscription provided a frame and point of reference to initially uncover the textual dynamics at play in the day hospital. They did not however allow for notions of human agency nor resistance. As Turner (1987) argues, given the power of discipline

and surveillance it is difficult to know how one would explain or locate opposition, resistance and criticism to medical dominance. In Discipline and Punish(1979) the body becomes somewhat disembodied, the biological, physical or material body can not be fully grasped as its existence is deferred behind the grids of meaning imposed by discourse. The body is affected by discourse but one gets little sense of the body reacting back and affecting discourse, consequently the corporeal phenomenon of the body is often lost.

Kapitzke, influenced by Foucault, places her understandings of the body within a poststructuralist perspective:

> In poststructuralist theorising, the body is viewed as a writing surface, a blank page, upon which social messages, meanings and values are inscribed. Embedded in relations of social power, material processes mark bodies and inscribe them with properties of subjectivity and identity. The inscription of bodies in Western culture occurs violently through confinement in prisons, hospitals, psychiatric institutions and rehabilitation centres and less coercively through 'voluntary' cultural values, commitments, and mores (Kapitzke, 1995:16).

Grosz (1990) argues that bodies within differing social and cultural networks can be viewed as "living significations and as social texts capable of being read and interpreted"(In Kapitzke, 1995:16).

Thus the body can be conceptualized as a social text upon which cultural fictions and narratives map meanings for self and other. External messages on the surface (tattoos, body piercing, tribal scarring, clothing and hairstyles) codify bodies and generate human subjectivities.[2] They mark the kind of individual to be constructed, the cultural and political position occupied and the ways in which these positions are inhabited. In the day hospital, the body is created through the medical gaze and through corporeal inscription into a particular kind of body: the diabetic body, the diseased body, the contagious body and the gendered or reproductive body.

[2] In Chapter Three I discuss how dress style and body comportment can symbolize or signify in space.

Human subjectivity is not a single uncontested entity but is characterized by tension, processes of conflict and ongoing transformation. These ongoing processes invest the body with agency; the body is not merely placed within a passive position in which meanings and messages are inscribed but is an integral component of human agency, acting people are acting bodies. Furthermore, it can be argued that patients take these inscribed and imposed cultural texts and rescript them for other purposes and for purposes which might not necessarily be medical in origin. The dynamics between agency and capacity for praxis will be explored.

Goffman(1961) and Foucault(1979) have demonstrated that the inmate or patient of total institutions, such as hospitals, asylums and prisons, undergoes a series of identity transforming experiences, rituals and textualizing procedures that serve to register the patient as an **institutional text** within the observational and record- keeping circuits of the institution. These studies trace the manner in which the patient becomes visible and an object of intervention in the total institution and the way in which the patient is read into institutional 'memory' as an assemblage of diseases, symptoms, behaviors and signs, for these practices both embody and replicate the exercise of medical literacies as forms of power upon the body and \or mind of the patient. Thus practices of induction such as temporal scheduling, spatial organization and body surveillance by clinics and prisons are exercises in and displays of the power of institutional literacy to which the inmate or patient must comply. Thus under the term "the medical gaze" one can include formal practices of institutional reading; recording, encoding and decoding technologies and practices that make up operative medical literacy.

In the day hospital the body becomes a contested text to be 'read' in many different ways. I explore the manner in which patients construct their own sense of identity under the medical gaze and from the 'read' parts of their body. They often relinquish and hand over these textualized sections of their bodies to the power of medical literacy and through consciously deciding to re- locate certain aspects of their bodily experiences within the medical space. It is my contention that the manner in which

patients deconstruct and understand operative medical literacy influences their view of self, their view of their bodies and their positioning within the institution.

However, patients may experience and interpret their bodies in diverse ways which often results in a situation whereby mainstream alphabetic literacy and experiences of medical objectification are submerged or rescripted to a form of body literacy. In this process of translation, patients begin to 'read' their bodies through their experiences of pain, dis-ease and body symptoms and in ways that frequently locate somatic phenomena within their daily discourse. Translations of alphabetic and medical literacies are frequently reconstituted within metaphorical or symbolic language which in turn is often embedded within everyday speech or rhetoric.[3]

Resistance practices arise out of the possible dissonance between patients' local literacy practices and the institutional literacy practices of the medical domain. It is at the interface between community and medical discourses, between providers and recipients, that the struggle of the body is enacted.

This contradictory situation, whereby the body is on the one hand subordinated, monitored and regulated and on the other hand is in process and invested with **human agency**,[4] is the bedrock upon which I place my ensuing argument and the manner in which I 'read' the body in the day hospital environment. This reading of the body can be conceptualized as tripartite. I juxtapose my own voice through my fieldnotes and observations with those of informants and how they construct their bodily experiences of medical literacy. The third voice is that of the medical institution and those representing it and the manner in which the body is 'read' by them.

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[3] Common examples are monthly's, three monthly, nerves, sugar diabetes and *die inspuiting* (the injection).

[4] Feldman's(1991) study of the construction of violence, the body and history in Northern Ireland provides a detailed account of agency particularly as it relates to the construction of political agency. Political agency is conceptualized as an embodied force.

I extend the spatial analysis of the previous chapter to explore the manner in which the body in the medical space is symbolically spatialized through the textualizing processes of induction into the institution (through recording, encoding and classification techniques discussed in Chapter Two and Three) and secondly, how these textualizing processes in turn compartmentalize the body into spatial components. The symbolic spatialization of the body occurs on many levels; left and right, above and below and the sacred and profane.

Hertz's (1960) analysis of the right and left hand translated into bodily divisions of left and right can be seen as having wider applicability to the human body and society and permits a synthesis of a spatial and somatic analysis.

> The difference in value and function between the two sides of our body possesses therefore in an extreme degree the characteristics of a social institution. (Hertz,1960:93)

These spatial divisions between left and right are useful in deconstructing and providing conceptual tools to understand bodily dissonances. Patients appear to separate or distance themselves from their bodies or sections of their bodies, and hand over certain parts to the normalizing practices of medicine. Medical technologies 'operate' by detaching certain body parts, a wound to be healed, a womb to be 'closed' and 'nerves to be calmed'. Patients distance themselves from these parts of their bodies in order to relinquish them to expert knowledge systems and medical literacy.

This process often becomes a mimetic process that is rendered habitual or even unconscious. Mauss(1973) advances the idea that **techniques of the body** can be learned and are culturally located, and that we learn to use our bodies through imitative actions of those in power or those above ourselves. These concepts were illustrated in the Family Planning and Baby clinic.

4.2 Baby clinic

My field notes reflect the silences and disassociation from pain and dis-ease. In the setting of the Baby clinic, the baby becomes a **text** to be read by the medical institution.

> I arrange with Sr. G to attend the baby clinic. I sit as an observer inside the consulting room. I am joined by two student nurses. The babies are receiving their state regulated vaccinations. The immunization schedule is inscribed on the baby's clinic card and mothers are informed via these notations when to return for the next vaccination. I note that there is minimal interaction between the mother and the baby. A nurse instructs a mother how to position her baby so as to enable access to the injection site. The constant sounds of wailing as the babies receive their vaccinations is disturbing but it appears that I am the only one who is distressed by the constant cries. Few mothers react visibly to the sounds and cries of pain. The nurses continue to examine and immunize, while the mothers sit passively. A large portion of the nurses' time is spent writing on the baby's immunization cards and in their files. Weights, temperatures, lengths and heights are measured and recorded and there is minimal discourse between mother and nurse. A mother returns to the consulting room stating that her baby has not been weighed. I am struck by this incident as the baby had been weighed in the mother's presence a few minutes earlier. The mother had either forgotten which was unlikely considering the time frame involved or perhaps in an indirect manner she was questioning the baby's weight[5] (FN. August, 1995).

"Rites of separation" thus form the crucial part of induction into the baby clinic.[6]

According to Foucault:

> The **examination** became the instrument for linking the exercise of power (surveillance) to knowledge forms. The normalizing gaze of assessment makes it possible to qualify, to classify, and to punish. It establishes over individuals a visibility through which one differentiates them and judges them. That is why, in all the mechanisms of discipline, the examination is highly ritualized. In it are combined the ceremony of power and the form of the experiment, the deployment of force and the establishment of truth. (Foucault,1979: 184)

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[5] Not gaining sufficient weight, often referred to in the colloquial as not "picking up", is a concern to both mothers and health care workers.

[6] Van Gennep's(1960) rites of passage schema depicts three distinct stages ; preliminal rites of passage (rites of separation); liminal rites (rites of transition) and postliminal rites (rites of incorporation).

In this instance the baby becomes the detachable part and for a brief period of time the mothers relinquish their babies to the medical sphere. The institutional space has power over the mother via the baby. Immunization is mandated by the Department of Health and thus forms part of the record -keeping circuits of public health care provision. In this instance, the mother becomes the second record -keeper. The mothers are able to ease their responsibilities from the domestic sphere (child - rearing) and for a brief period are able to hand over the responsibility to the medical sphere.

I remain perplexed by the silences and apparent distancing from these uncomfortable experiences. Discourse in this space is expressed in contradictory ways, either through laughter and animated conversation which resonate in the corridors and doorways or alternatively through subdued silence inside the consulting room. While there appeared to be minimal interaction between mothers and staff where reading, recording and quantification was concerned, I found in my subsequent conversations with the mothers that they were able to decode and distinguish between different medications. They were often able to identify medicines by name, yet these were the same women who either did not know the name of their contraceptive injection or referred to their injections as *die drie maande* or *Depo iets* (see following section). This led to the realization that literacy practices in the context of child health required certain discursive skills or understandings of medical literacy which were not necessarily linked to print literacy, rather they required a socialization or re-contextualization of medical technologies and hence medical literacies within everyday social context and practices. Reflected in the following comment :

> I am always needing those medicines as my children are often sick with colds and chest troubles. We always need those antibiotics and cough medicines. The other child gets those allergies from eggs so I must also get that zinc salve for the rash.

This mother is able to distinguish between body signs and symptoms and identifies and correlates appropriate medicines, an antibiotic for a possible recurrent chest

infection and a cough suppressant for a perpetual cough. She later informs me that her "one child was born like this, always with a non-stop cough."

The mothers are able to access the necessary knowledge in diverse ways and in ways that do not necessarily require the ability to decode texts. Reading and writing do not necessarily play a privileged role in the literacy event which goes far beyond decoding the texts on medicines bottles and clinic cards. Access to these discourse systems are not necessarily access to power but are negotiated and mediated through their own everyday practices and discourse systems.

4.3 Contraception and Family Planning : Gendered and spatial polarities

This section on the women attending the Family Planning clinic constitutes the central focus of this chapter. This was a conscious choice allowing for more in depth study. I extend the spatial analysis of the previous chapter to the Family Planning clinic as representing and symbolizing feminized space, a safe space beyond the male gaze. A space where women's bodies are safe- guarded against male domination and violence within the domestic and community spheres. [7] The women are often able to map the disorder in their daily lives through descriptions of their experiences within the domestic sphere. The home environment is often the central focus or point from which most discourse about their daily life experiences emanates.

I return to Kapitzke's(1995) depiction of literacy as a set of social practices using a technology of inscription. The action of the contraceptive injection can be viewed as a powerful signifier of medical technology, it is a form of corporeal inscription on the female body and marks the body as sealed and closed. I initially conceptualized the contraceptive injection as a technology of power(Foucault) over the minds and bodies of women, but came to realize that the process of inscription was more complex. The

[7] I use the term violence cautiously as it denotes diverse experiences of social violence which may not necessarily take the form of bodily or physical harm. Violence emanates from everyday experiences within this community ranging from gang activity to forms of social violence in the domestic sphere. Practices of violence are frequently alluded to by the women that I interviewed, they are often hidden within their discourses around domesticity.

manner in which power is inscribed on the female body through the processes and mechanisms of self-regulation, supervision and social control is fragmented.

I introduce the concept of hegemony which is Gramsci's (1971) term for the discursive face of power. The notion of hegemony points to the intersection of power, ideology and inequality. However it does not imply that dominant groups exercise an absolute top- down control over meaning. Rather, hegemony designates a process wherein cultural authority is negotiated and contested and where individuals speak from a plurality of positions and perspectives.

Identity, more specifically gender identity, can be conceptualized as a matter of agency, constructed and negotiated in historical and political contexts. Recent feminist scholarship has been attentive to the multiplicity of social relations that structure women's identities in interdependent and contradictory ways.[8] The experience of being a woman particularly in South Africa, is different depending on how one is positioned in terms of race, class, ethnicity, religion and during apartheid. I view identity as non-essentialised and emergent from a historical experience.

I explore the cultural constructions that exist around the concept of **contraception** and how it relates to the gendered body in the Family Planning environment. Women create their own meaning systems around contraception and organize their gender and body identity around different medical technologies or forms of contraception, the oral contraceptive the 'pill' as opposed to the contraceptive injection (*die inspuiting*).

Differing techniques or technologies of inscription are imposed or inscribed on their bodies, such as the recording of their blood pressure and weight, to the final act of inscription, the injecting of the contraceptive drug into the muscle. I suggest that the act of **injecting** is a powerful act of inscription.

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[8] Nancy Fraser(1992) provides an interesting perspective towards feminist debate and its place in discourse theory. She argues for a feminist social theory that conceptualizes social identities as complex , shifting and socially constructed as opposed to reified, essentialist conceptions of gender identity.

I identify two discursive positions in this milieu. On the one hand, women experience a sense of autonomy and choice over the reproductive functions of their body, yet on another level they relinquish their bodies to medical technologies. I will attempt to uncover the complex discursive processes at play in which the struggle over the body is enacted through embodying and transcribing medical technology.

The contraceptive injection, Depo Provera as medical icon and powerful signifier is re-contextualized and re-transcribed by the women attending the Family Planning clinic as having both symbolic and material possibilities. Firstly, it is imbued with magical or in medical terminology "unscientific" properties. Secondly, in real material terms it affords a degree of personal autonomy over their bodies and in their day to day living but thirdly it also reflects the power of medical technology and discourse which is both racial and gendered in its origins. Ideological discourses can play a crucial role in the maintenance of asymmetrical power relations. Women adopt medical literacy or technologies as they hope it will open up new worlds and identities and overcome their subordinate positions in the domestic sphere but these genres also reproduce dominant gender stereotypes.

4.3.1 *Family Planning as key event*

> The staff are busy preparing the space for the Family Planning Clinic. Women of various ages, ranging from eighteen to thirty are slowly trickling in. Some are sitting and breast feeding their babies, others arrive from the nearby fishing factory wearing their gumboots and *doeks* (headscarves). The women position themselves either in the main waiting room or directly outside the Sister's consulting room. Procedures are clearly structured by means of rows, queues, cards and folders which not only simplifies matters for the staff but gives patients the security that they can rely on the system and will be seen in an ordered fashion. This allows them to wander off outside to smoke, sit in the sun or to purchase foodstuffs from the shop. They know that they will not lose their place in the queue as they inform me that friends will locate them should their name be called in their absence. A patient places the clinic cards in numerical order, a staff member thanks her for her help. The neighbourhood is present during this event and overwrites the official intention with local practice. The informal organization of space is a confirmation of local and community identity. Dialogue is noisy and animated, the women appear to view me with amusement and curiosity. I sense throughout my interviewing that I am a source of great amusement, they continue to chat loudly and laugh when I ask them what the name of their pill or injection is. A few of the older

> women prompt the younger women. They state in unison, Depo *iets* (Depo something) referring to Depo Provera. [9] A simple procedure is followed; the women are first weighed, their blood pressure is recorded followed by the injection which is administered intramuscularly into the buttocks. Events at the Family Planning clinic are transformed into communal practice. Women accompany each other to the Family Planning clinic where they are likely to meet friends and acquaintances. There is a convivial ambiance with much laughter and noise. The nursing staff recognize many of the patients and communicate with them in their own vernacular. Women entrust their bodies to the nurses' skill the corporeal and visible practice on their bodies provides a particular and powerful performative moment (FN, 6/9/95).

I am perplexed by all the laughter. In Chapter Three, I discuss in the context of carnival how laughter frequently signifies a challenge to the monologic voice of the institution and conclude that the laughter I encounter is an indication of how formal space has been informalized. I sense that the laughter around our discussions of contraceptive choices and 'naming' is not about being uncomfortable or awkward. By my asking them the name of their contraceptive it is in a sense "matter out of place". (Douglas, 1966:40). The women come to realize that knowing or memorizing the name of their particular contraceptive injection is not necessarily empowering. There are other ways of accessing power which I discover as the narratives unfold.

A dilemma that I faced was how to position myself within the Family Planning environment. A questionnaire was compiled but was never presented to the women. [10] On reflection and in tandem with my own development, I realized that my questionnaire was framed within medicalized discourse and I questioned some of its relevance. I felt however that in some way it highlighted certain trends and used it as a guide and reference and to help structure my own interactions with the women that I spoke to, this prompted lively social interaction. My gender, age and use of the vernacular allowed for a less formal interchange and we were able to negotiate our respective positions.

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[9] Depo Provera is administered as an injection every three months. Common side effects of Depo Provera are: irregular bleeding, amenorrhea, weight gain and delayed return to fertility.

[10] Refer to questionnaire in Appendix 1

The following general trends were noted:

1. All with the exception of one woman who was new to the area and who positioned herself in a different space to the others were receiving the contraceptive injection Depo Provera. No one was on the oral contraceptive 'the pill.' The response to why many women had not chosen the pill was uniform, a few women laughed quite spontaneously. Collective answers in unison to questions about the pill were :

> We hate the pill.
> We forget and then we're pregnant.

There is a causal relationship between pregnancy and the pill, the polar opposite of its intended actions. I explore this further below.

2. Few knew the name of their medication. "*Depo iets*"(Depo something), "*die inspuiting*" (injection) or "*drie maande*"(three monthly) was a popular response.

3. Most women did not display concern over the fact that they did not know the name of their contraceptive. They did not appear embarrassed nor uncomfortable, rather they appeared amused by my questions.

4. Few knew their weight, they did not look at their recording nor did they request to be informed of their weight. My own experience has been that it is often the first concern that women display as one of the side effects of Depo Provera is weight gain.[11]

5. Most did not know their blood pressure, they did not ask, nor were they informed. Echoed in the following utterances:

> The sister knows what it is, why must I know?
> Sister will tell me if it is high so I don't worry.
> If it is high she will tell me.

[11] Body image varies across cultural contexts and is often a culturally coded practice.

I realized that it would mean very little even if they knew the quantitative value. Almost all the women stated that if their blood pressure was high they would be informed.

This textualizing process is yet another example of how operative medical literacy further objectifies their bodies. These classificatory technologies forms an integral part of the relinquishment or handing over process, in which the monitoring or self-regulation of one's own body is transferred through these textualizing processes to the medical domain.

6. Most stated that they were forgetful and that is why they preferred the injections or the three monthly's (*inspuitings or drie maande)* to the pill.

Selective appropriation of medical technology is reflected in the following observations; women return timeously for their appointments, the adherence to the queue structure suggested by one woman's eagerness to facilitate the process by placing the clinic cards in numerical order, in the safe- keeping of their clinic cards and finally in the overwhelming response to the 'choice' of Depo Provera as a form of contraception.[12]

The women have adopted their own vernacular discourse around 'naming' or medical terminology. The contraceptive injection as medical technology, has been incorporated into the local vernacular, *drie maande*, *Depo iets*, *die inspuiting* and has taken on its own cultural meanings often with extra-medical ramifications. There is a certain communicative genre centred around the injection and socialization of medical technology and terminology into their everyday language and practices. I explore the complex meanings and significations centred around contraception through the narratives of the women interviewed. The following fragments of speech reflect the manner in which these women have created their own meaning systems around the transformative actions imposed on their bodies. They have redefined and forged new meaning systems for themselves around the purported freedom that

[12] I use the word 'choice' cautiously as these choices have both gendered and racial undertones.

contraception has afforded them. I locate my ideas in the narratives that these women recounted in response to discussions concerning contraceptive choices, health and the family.

> I just have to look at the pill and then the next day I am pregnant.
> I am too forgetful. I can't remember to take the pill everyday.
>
> *As ek die pille vandag neem dan is ek môre swanger.*
> If I take the pill today then tomorrow I am pregnant.
>
> *Ek vergeet die pille. Nee dankie, ek wil nie meer kinders hê nie.*
> I forget the pills. No thank you, I do not want any more children.
>
> I like the injection. I don't like pills. I am not scared of the injection because I don't want anymore children.
>
> *Die inspuiting laat my hol seer. Maar ek worry nie.*
> The injection leaves my arse sore. But it doesn't worry me. I like the injection it is better all round.
>
> *Ek is op die drie maande. Ek haat pille. Ek is nie bang vir die inspuitings nie. Ek wil nie meer kinders hê nie, maar ek wil ook nie dat hulle my laat toe maak nie.*
> I am on the three monthly. I hate pills. I am not scared of the injections. **I do not want any more children, but I also do not want them to close me up.**

The notions of safety and surety associated with the injection in contrast to the pill's unreliability is symbolized in the utterances by a young woman of twenty. The injection is a surety in an otherwise uncertain world.

> I only have to look at the pill and then I am pregnant. No thank you Miss, I do not like the pill. You see this baby here, that is what the story of the pill is about. You see I just can't remember to take the pill everyday. How must I remember? There are so many other things that one must do like take children to school, shopping, cleaning and such.

The powerful optics and mythological structures centred around the pill is reflected in the following extract:

> I only have to look at the pill to make me pregnant. Once I see that injection coming then I ask no questions (laughing). Sometimes I can feel the Depo running down my leg. [13] I am used to the injections, it is only every three months so I don't mind. That injection doesn't really hurt it goes in fast. It's over quick. One gets used to it. I'm used to injections I've been having it already so many times.

In contrast, the response by a woman new to the neighbourhood was quite different. I sense a spatial segregation. She is positioned in the far corner of the waiting room separately from the other women. She is holding a small baby wrapped up tightly in a shawl. She tells me that she has recently moved to the area from Sea Point.

> I take Triphasil[14]. You see I had problems with my periods *op daardie inspuiting*. (on that injection). I had to take *yster pille* (iron pills). I am happy with the pills. I would definitely not try the injection again. If left with no option, then I will rather use nothing.
> Me: What about condoms?
> No, definitely not Miss. My husband doesn't like them.

The responses were so overwhelmingly in favour of the injection that I was initially perplexed. I realized that the desire for the injection as opposed to the contraceptive pill was significant. I remained puzzled by these apparent discontinuities and could not ignore the controversy and negative inferences surrounding Depo Provera and its place in feminist discourse and medical debate. The use of Depo Provera as a contraceptive method advocated, distributed and popularized in Third- world countries has associations of curtailing the rights of women over their own reproductive processes. [15]

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[13] This is a common complaint and is most likely the sensation of the medication as it enters a muscle.
[14] Triphasil is an oral contraceptive.
[15] Refer to Mercer & Knowles(1992:107-108, In Donald, J & Rattansi, A. 'Race', Difference & Culture) to further debates about the use of Depo Provera on Black women in Britain. It can be noted that Depo Provera did not meet the necessary safety standards in Britain nor in the USA.

Contraception has become a colonizing practice against many women in the Third-world or where population development and control is an important political agenda e.g. China and India where restrictions are placed on women's reproductive capacities, such as limiting the number of children per family. My gloss on Depo Provera is that it has become a normalizing and disciplining practice through its advocacy as a reliable, efficient and safe method of contraception.

The key question then was:

- Why was there such an aversion and articulated resistance to the pill ? and
- Why was the injection so important in their daily lives?

On first reading I found this situation contradictory. My biased attitude towards Depo Provera as a method of contraception further facilitated my quest to explore these apparent contradictions. I realized that I had to abandon my own pre-conceptions. I could not ignore aspects out of which my own identity had been constructed and my prejudices towards Depo Provera. The injection had been popularized not only by state and public health discourse but by the women themselves. Its efficacy as a form of contraception is well documented and a possible side effect is sterility. This was never acknowledged nor inferred in any of the conversations that I had with the women though one woman was quite adamant that she did not want to be sterilized (she did not want to be closed up) and I assumed that sterilization as a form of birth control was not an option for these women.[16]

The contradictions and paradoxes that emerge around specific notions of the injection as against the pill or other forms of contraception, reflects the multiple and contradictory ways in which ideology works and reflects different hierarchies of power (husbands, male partners and public health discourse). The manner in which women's bodies are read, narrated and re -narrated by the medical and public health

[16] I base my assumption on the fact that they have chosen the injection and not sterilization as a form of contraception. It is ironic that injectable contraceptives are now a popular choice amongst the "career or working women" and are being marketed as such.

discourse particularly during the apartheid era, is an ideological practice that can frequently involve wider yet disguised social norms and codes of racial, gender and class inequity which serve to underwrite and to reinforce the socialization of these women to institutional power and social control. Political intervention with its metaphors of population development and control, planned parenthood and responsible choices is equated with medical rationalities typified by conjecture: " A Planned Child has a brighter future." [17]

Deconstruction of the following text from a medical textbook directed towards Family Planning practitioners depicts the hierarchical and ethnocentric character of state sponsored discourse and prescription.

> Contraceptive hormones administered parenterally are very effective, safe and especially suitable for lower socio-economic patient populations. In the RSA, about 60% of all clinic patients make use of injectable contraceptives.....Its theoretical effectiveness is practically 100% when used correctly. In a study done by the WHO over almost 3 million cycles, it was found that its effectiveness is similar for different socio-economic cultural and nutritional conditions. It is especially suitable for those who believe that injections are more effective than oral preparations and **those not always sufficiently sophisticated to use pills** (Theron and Grobler,1987 :54).

Ironically similar sentiments are voiced by the women themselves; " sufficiently sophisticated" can be translated to, "I can't remember I forget", "I can't remember to take a pill everyday" and "I am too forgetful". In a sense these notions of carelessness and irresponsibility become self -replicating stereotypes. Similarly, "those who believe that injections are more effective than oral preparations", can be translated to the almost mythical qualities surrounding the power of the injection in this community.

The manner in the which the pill versus the injection is constructed by both patients and medical discourse can be symbolized in stereotypical **gendered polarities** of male and female. The pill embodies female attributes, it is unreliable, disordered and capricious whereas the injection is male, powerful and structuring.

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[17] A standard logo displayed on posters pertaining to Family Planning.

Injections symbolize strength and potency. These beliefs around the injection are now firmly embedded in this community, re-articulated and re-contextualized taking on their own local cultural meanings. In Chapter Three I mention a patient who is concerned that she is no longer receiving the strong injection for her "nerves". Kleinman's(1980) study of health care in Taiwan, indicates that in patients' interactions with Western -Style doctors, injections are the essence of what is powerful in western medicine. In contrast to certain traditional Chinese medicines, the injection represents the modern side of medicine. It is stream-lined, quick and easily administered as opposed to the more cumbersome and time-consuming traditional Chinese medicines.

4.4 The hidden practice of the injection

The women at the clinic saw a direct causal relationship between the pill and pregnancy, the polar opposite of its intention. Both the pill and injection are imbued with magical qualities reflected in such comments as : "I only have to look at the pill and then I'm pregnant" and "if I take the pill today then tomorrow I'm pregnant." The rapidity with which conception occurs is an obvious hyperbole but it serves to re-contextualize the injection's unequivocal place in the contraceptive arena. The final proof of the pills' unreliability (and hence femininity) is a reference to the baby that epitomizes "the story of the pill" this reference to the baby is tangible proof of its inefficiency. The injection as concealed practice is transformed into a closed signifier where there are no babies to be seen nor pills to be hidden. The injection becomes not only **invisible** but **invincible.**

I now explore the cultural construction around the powerful optics of the pill as opposed to the hidden practice of the injection. The power of the pill's visibility is reflected in the following narrative recounted by a young woman of twenty.

> Often our husbands or men want us to have more children. I say no thank you, not me. You see Miss, I had this friend she was on the pill she had to hide it from her husband so she hid it in the kitchen and then her husband found it and he was angry and threw them away but then I told her just tell him these pills are to make you, you know, your periods regular and such.

> Another friend she hid her pills but then she would forget where they were hidden, you see it is no good. This system is no good. The injection it is better all round. You know these men they want us to have more children but it is very costly to bring up children these men don't think about that. The injection is safe. My time is too busy to remember to take a pill everyday.

The pill is kept in the house, which is dominated by the male gaze. The husband discovers the pill and destroys it. The injection is hidden from the gaze of their husbands, it occurs every three months in a clinic beyond local male control and thus beyond their gaze. The pill is visible, a practice that occurs in the home and thus subject to the male gaze. In hiding the pill and hence concealing the action, resistance and defiance is directed towards male domination in the home.

The clinic embodies feminized space, it is beyond the field of the male gaze in the domestic space. The injection like other medical practices is also a hidden or invisible practice and another power which organizes women's bodies in a relational fashion and that detaches them from male control in the community and domestic sphere. The female body thus becomes a relational nexus between these two systems of domination.

The following narrative reflects the negative dynamics, expressed through the sentiments of "bad feelings", associated with the pill, though in a different context.

> I do not like pills. I have a bad feeling about them. My husband would not mind if I took the pill, but it's just a thing I have about pills. You see when I was younger I took all kinds of pills to forget about the way my family treated me. Bad things happened to me by my family. I would just take any pills to make me forget. Now I rather take the injection because I do not want to remember my past and pills will always give me a bad feeling. I can't help it, it's just like that for me.

The pill is associated with the disharmony in the home and with this young woman's unhappy past. Domestic violence is implied but not explicitly articulated, a theme which is to re-occur.

The power and strength of the injection is expressed in the following vignette.

> It is a warm sunny day, a group of women surrounded by babies and toddlers are sitting outside on the steps. I join a woman who is sitting slightly to one side. I ask whether I can interview her. She appears amused. I notice that she has gold stars inscribed on her teeth.
> Me: I met someone here the other day with similar gold stars on her teeth.
> Informant: *Ja*, (Yes) it's a dentist in Mitchell's Plain who does it.
> We discuss the unpredictable Cape Town weather.
> Informant: I am here for the Family Planning Clinic, but I also came to get *pille* (pills) for my shoulder blade.
> Me: What happened?
> Informant: A wardrobe in the bedroom fell against my shoulder blade.
> Me: That must have been very painful. Did it fall over ? (I notice that she has a large bruise around her left eye.)
> Informant: It just fell against my shoulder. Maybe my husband tried to move it against me. Maybe he had too much to drink last night.
> She then changed the subject.
> Informant: I get *die drie maande*. No thank you Miss I don't want no more children. I have this nerve problem as well. I take pills for the nerves. Before I was on the injection for *senuwees* (nerves) but the doctor said I should now try the tablets, but all in all injections are more strong and get the nerves calm. I have three children, no more because it is a lot of work and also all the troubles of having a baby. You only realize this afterwards. You see, *dis*(it's)
> ***In soos 'n piesang en uit soos 'n pynappel.***
> **In like a banana and out like a pineapple.**[18]

The symbolism in the above statement refers to the opposition between smooth-rough corresponding to a pleasure-pain dichotomy as experienced in sex and childbirth. The comparative ease with which the contraceptive injection is inserted can be likened to the relative ease within which the metaphorical banana is inserted, thus the injection goes in "like a banana". Women claim that it "goes in quickly", "it does not really hurt" and if it does cause brief discomfort they "do not mind because they are "used to it" as "it is only every three months." Thus the injection permits sexual relations whilst also preventing pain associated with childbirth.

In discussion with another health care practitioner I learn that this expression, like the *"drie maande"* and *"senuwees"*, forms part of local discourse around painful childbirth. In keeping with other inferences (towards her husband and her shoulder

[18] Unfortunately the alliteration of the 'p' in *piesang* and *pynappel* is lost in the English translation.

injury) it is not surprising that she discusses sex in metaphorical language and through memories of painful childbirth. She is reading her body experiences in symbolic form. There are inferential references to domestic violence, her husband who **might** have pushed the wardrobe cupboard against her and her bruised eye. Through body symbolism or attempts to read her body(somatic literacy) and through memories of painful childbirth, the 'pain' of unwanted pregnancies and her "nerve problem" she is able to re-articulate her dis-ease which has both medical and social implications.

4.5 Defeminization of the body

Through the alteration of cyclical rhythms of menstruation and fertility one woman's image of herself is altered, reflected in the following extract:

> *Ek is bangerig vir die pille want ek is forgetful. Ek wonder hoekom ek gewig opgetel het?*
> I am kind of scared of the pills because I am forgetful. I wonder why I gained weight?
> *Me: Weet jy hoeveel ?*
> Me: Do you know how much?
> Patient: *Nee (*No.)
> *Ek is ook bekommerd want my monthly's*[19] *is net so druppels, maar my ma het my vertel dis OK.*
> I am also worried because my monthly's are just drops, but my mother told me that it was OK.
> Me: One of the results of Depo Provera is that you can gain weight and often not have a period at all.
> Thank you, now I feel much better. You see I don't want anymore children but I must also still feel like a woman.

She needs to "still feel like a woman" and for her, feeling like a woman is constructed around her menstrual cycle, reproductive abilities and choices. She reads her bodily changes by expressing her concern over scant menstruation (*"druppels"*) which in turn is read as a defeminization of her body. She too, reinforces the hidden symbolism of her femininity and reads her bodily changes in terms of being divested of her womanliness. This is counterpoised against her material realities of not wanting anymore children. These physical changes which impact on her body and concept of womanliness leads to a further disassociation from her body.

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[19] Monthly's is the vernacular for menstruation or monthly periods.

4.6 The unspoken body, another hidden practice?

Issues around safe sex practices and the prevention of sexually transmitted diseases(STDS) and AIDS is the silent narrative in this institution. If it is dealt with it is in a cursory manner or from a position which is infused with the narratives of morality and the ethics of acceptable sexual mores and behaviour.

There are numerous posters on the walls alluding to AIDS and hepatitis but the use of condoms as a means of preventing the spread of sexually transmitted diseases is not addressed in a direct manner. There is a poster with a collage of condoms in red, yellow and green on display in the reception area.[20] A further example is a poster above the reception window, here the imagery is an attempt to romanticize condom use, yet ironically it forms the walls of the institution.(see Plate 6)

The distribution of condoms however is neither visible nor is it openly discussed. Condoms that are dispensed are placed in an awkward place, partially concealed behind the glass window of the reception area and thus not easily accessible. Clients are thus obliged to ask the receptionist for condoms. The administrative as opposed to the medical staff dispense condoms. This could have multiple meanings and as such could structure the perception of condom use, as something furtive, hidden and not fully sanctioned by the medical staff thus becoming a further **hidden** practice. Many patients are well acquainted with the receptionist and vice versa, her religious standing in the community further serves as a social and moral discourse on acceptable sexual behaviour.

Most of the female patients laughed when I asked about condom use. There appears to be a code of reluctance and hence silence around the use of condoms, either as a form of contraception, or in the prevention of STDS.

A discussion with Sister G further suggests the moral discourse around the use of condoms leads to a further hidden practice. Our discussion took place in the tea room

[20] This is an obvious image of a traffic light.

during her lunch break. I ask about the box of condoms located behind the glass window of the reception area. Alongside the box is a hand written sign inscribed with the word Condoms.[21] I had not noticed the box before though I am assured that it has always been there. Sr. Joan, the receptionist, informs me that: "If they want them they must come and ask for them. Condoms are mostly dispensed to the men, though a few women do ask for condoms." My discussion with Sr. G ensued:

> The use of condoms in the Coloured community is often seen as a sign of promiscuity, it means you are sleeping around and you want to protect yourself. Teenage pregnancy has increased this year. I am so disappointed. I would like to set up a Family Planning clinic at the high school but that is a problem. There is a negative connotation to the use of condoms in this community. It means that you have more than one partner or that you are sleeping around, otherwise why do you need condoms ? I encountered some difficulties in distributing condoms to African men, being a Coloured woman these men do not like to talk about sex. My first experience I was blasted out. The Coloured men do not feel so embarrassed. Sometimes when they see me out in the community they ask me if they can have a whole box of condoms. Then I merely open my car boot and give them condoms then and there. Just like that.

These in- place cultural conceptions are not fully explored. Culturally sensitive issues around sexual practices and values are recognized but are not addressed. The culturally sensitive nature of condom use or non- use is recognized but it is left at the level of cultural or racial difference ("Coloured and African men") and peculiarity and not extended to forms of intervention which might include dealing with these issues of difference. This is an area that I would have liked to explore further. I recognize that it is not only a gap in public health care initiatives but also in my own research. Time constraints and the focus of this research did not make it possible. Perhaps one area of further research or intervention could include the cultural constructions centred around the symbolic value of producing children.

In an earlier narrative a woman refers to "husbands who want us to have more children." Galanti(1991) in a study amongst Hispanic men in America argues that children are proof of men's virility and in the face of poverty, status is derived from

[21] See Plate 7.

the number of children one can produce. Children are therefore a form of cultural or symbolic capital.

4.7 The disembodiment of the body.

I now intend to explore how the body is circumscribed not only by the discourses of medicine but by the patients themselves. I will examine how the temporary appropriation and ownership by the discourses of medicine, through various normalizing procedures, serves to reinforce the bifurcation of the body to self and other. I discuss the manner in which stratified bodily boundaries around issues of pain, anxiety and social violence intersect with the subtexts of race, gender, class and cultural conceptions of the body. In this dynamic patients relinquish and hand over these textualized body parts, sensations and body experiences to the powers of medical literacy. I would argue that this transference is not an uncontested process but requires complex negotiations.

One of my earliest recordings considers what I refer to as lack of privacy which can be depicted as a transgression of bodily boundaries. I detect a sense that patients are distancing themselves from parts of their bodies. These are the first indications of bodily disassociation.

> The treatment room is a hive of activity. A nurse is busy administering various treatments. I feel awkward standing amidst all this human discomfort and ask whether I can be of assistance. I sense that I might be viewed as monitoring or observing her nursing techniques. In the nursing hierarchy I am positioned "above" her. This becomes obvious when she addresses me as "Sister" despite attempts to define my role as a researcher. Bodily boundaries and gender divisions merge into one. A mother is breastfeeding her fractious baby, whilst another woman is having a dressing changed to a wound on her breast, she is positioned with her exposed breast alongside a man in factory overalls receiving a breathing treatment. Next to him is an elderly man who is having his ears syringed. People come and go, the man receiving the breathing treatment is looking straight ahead. I notice that his breathing treatment is complete, yet he remains seated. I have to restrain myself from turning the oxygen off. The oxygen is eventually turned off. A man with a stab wound to his chest sits in silence waiting to have his dressing changed the only sounds are those of pain. I am perplexed by this impassivity (FN., 22/8/95).

Bodily boundaries between public and private spaces are similarly transgressed in the domestic sphere. In the often overcrowded living conditions, the notion of privacy is a privileged one, where family members of differing age and gender share the same room.

4.8 Susanna and Yvette: *Two embodied biographies.*

On one of my first visits to the day hospital I meet Susanna who appears agitated and upset. She is conversing with the receptionist who is in turn consulting a large black book, an appointment book for monthly gynaecological examinations. She requests an urgent appointment. After a lengthy conversation and through personal disclosure I learn that her primary concern centres around a recent sexual encounter with a man who has had multiple sexual partners. She enlists my help.

> I am scared that I have caught that thing You know I am not one to lie around, but this man I heard he had lots of women, but he did not tell me. I didn't ask him, you know it was only one time. What must I do ? It's not like me. I had a husband but then he left me. I have four children they are all still at school. I was a seamstress but now I don't work anymore. I met this man. I thought he was nice, he has a good job. He treated me well. Then I found out from someone I know that he goes with lots of women. So now please tell them I need this test.[22]

Douglas (1966) talks about bodily boundaries or margins which are often linked to the symbology of pollution or impurity. "Caught that thing" personifies that which is unmentionable or has no name and is located on the margins of the body.
Bodily margins can be depicted as:

> All margins are dangerous. If they are pulled this way or that the shape of fundamental experience is altered. We should expect the orifices of the body to express its specially vulnerable points. Matter issuing from them is marginal stuff of the most obvious kind. Spittle, blood, milk, urine, faeces or tears by simply issuing forth have traversed the boundary of the body (Douglas, 1966:121).

Susanna's narrative required uncovering an elaborate array of metaphors and thinly disguised anxieties which were alluded to in an indirect manner. Her discomfort and

[22] From my medical perspective and experience I realize that this is an inappropriate diagnostic test for her complaint, other medical treatment is required.

dis -ease was redirected and transferred onto acceptable and sanctioned medical interventions and discourse around her own morality (She was not one to lie around). She was unable to name her 'shame' and hence felt that this normalizing procedure(a gynaecological examination) could serve as a panacea for her problems. It was in the medical gaze that she sought a resolution to her problem, both in the treatment of a sexually transmitted disease and in the treatment of her abdominal wound (discussed below).

Hertz(1960) talks about a fundamental dualism which exists between the right and left hand, the sacred and profane. The sacred sphere embodies that which maintains life and which gives health, the profane embodies the impure which is weakening and deadly. The right hand stands for me, the left hand stands for not me, for the other. Many symbols can stand in place of moral binaries; right and left, pure \ impure and order \ disorder. These symbolic representations can be translated into **order\ disorder**. Certain bodily boundaries had been transgressed. This bodily transgression had caused disorder on many levels, through the burn to her abdomen which was dealt with once she entered the medical space(represented by order) and to her possible STD which could only be dealt with once she had made an appointment, a further order. Thus symbolic resolution is sought through further bodily order, represented by medical technology and cure. Disorder in the domestic sphere is further symbolized in terms of her unemployment, four children to care for and a husband who has deserted her. Order is represented by the man with a "good job", but who has through traversing her bodily boundaries created further disorder. Her body thus becomes an open signifier.

I meet Susanna once again. She recounts how she has sustained an abdominal burn from a glass Coca- Cola bottle improvised as a hot water bottle to alleviate stomach cramps. I ask her if the pain and discomfort had not woken her during the night. She replies:

> No it is only when I saw how red my stomach was in the morning that I realized that something was not right. I then came to the hospital. Now they

will sort it out and give me some pain pills and put some salve on the burn. Remember my other situation, we sorted that out as well.

It is only once she enters the medical space that she is able to disembody her pain and trauma, by handing over or relinquishing the affected part of her body to medical technology. She thus moves form one state of embodiment to another. She was ready to show me her burn yet in her home she had ignored the pain and discomfort. Is it because people in this community have been socialized to suspend or submerge their pain and trauma until they enter the hospital? The hospital has become a place or space to resolve not only medically related problems but social problems as well. The psychiatric nurse tells me that "we are like social workers" and the medical institution is able to "sort out her problems." This serves to further reinforce the socialization of the patient to institutional power and rehabilitation.

The clinic and domestic space polarity is illustrated in Yvette's narrative and is paralleled in the pill \ injection polarity. The pill is unreliable occurs in the domestic sphere and subject to the male gaze. The injection is reliable it safeguards the body against unwanted pregnancies and is not subject to the male gaze within the domestic sphere.

I meet a Yvette a Xhosa -speaking woman in her twenties who resides in Mandela Park. She informs me that she is waiting to see the doctor. Our discussion is conducted in English despite the fact that she is Xhosa- speaking. Her English is fairly fluent and she tells me that she grew up near Tarkastad in the Transkei. She left school in Standard Eight and later came to work in Cape Town. She currently works as a waitress in a restaurant in Hout Bay.

My boss noticed that I was walking strangely and I was in a lot of pain. I had been like this for two days. (She then revealed a large bandaged area to her abdomen). I was told by my boss to come to the day hospital to have it seen to. My boss is a nice lady she said: "how can you work like this you must go now to the hospital". (She provided a further explanation as to how she had sustained the injury).
I was sleeping in my bed and then when I woke up I saw that my boyfriend's girlfriend had thrown paraffin over me that is how I got this burn to my stomach.
Me: Did you not wake up to the paraffin being poured over your body? (I did not mention that it must have been set alight).
Yvette: No, only afterwards.

I later discover that the wound had been inflicted two to three days prior to her initial hospital visit. Our interview was interrupted, it was her turn to see the doctor.
Yvette: If you like, give me your phone number and I will speak to you again because now I must go to see the doctor and then go back to work straight-away.
I saw Yvette once again and she informed me that her burn had healed.
"Now there is no more to tell, I am better again."

The dynamics of this incident are complex and fraught with implicit overtones of domestic violence. She has set the terms of her own dialogue. I am perplexed by her anesthesia.[23] Her voice was distant and quite matter-of-fact, she appeared to have submerged discordant and painful sensory experiences of domestic violence. She sat amongst the other patients and was interacting with them in a cheerful manner.

The violence (pouring of paraffin over her body) occurs in the domestic sphere, the medical sphere treats and heals the burn. She associates the wound with discourse, while it was painful, untreated and open it gave her a subject position from which to talk about violation in the home. Now that the wound is literally and symbolically closed (healed) there is no discourse, as the medical gaze has sealed it and terminated the discourse, reflected in her words "now there is no more to tell. I am better again". She also relates the violent incident through the voice of a third person (her employer)who notices and acknowledges her pain, suggesting a further distancing from her open body. Using Hertz's(1960) distinction between the left and right body, she has moved from the left side of her body, the body as vulnerable, opened and violated to the normalized body as sealed and closed as facilitated by medical treatment.

This is analogous in the injection /pill polarity, whereby the injection metaphorically seals the body through preventing pregnancy and the pill through its 'inefficiency'

[23] Cultural anesthesia is what Feldman refers to as: "the banishment of discordant and anarchic sensory presence's and agents that undermine the normalizing and often silent premises of everyday life"(1994:405). Recently, (July, 1996) I attended a conference which centered around issues of remembering. Panel members expressed the need to recognize and explore the silences and the non- voiced in peoples' testimony to the Truth and Reconciliation Commission.

opens the body causing pregnancy, though for these women the final act of closure (sterilization) is not a choice that they make. Women thus relinquish control in one space (the domestic space) to achieve it in another space(the medical sphere).

The burn is tolerated and endured, it is suggestive of the disorder, difficulties and possible bodily injury that women experience in and associate with the domestic environment. However, the home is also a place where friends and neighbours meet to watch television and videos. The social violence in the domestic sphere is never openly articulated but is often hidden in metaphors or narratives that are indirect in their implication, a theme that I have previously noted. Moreover, their discourse around the adverse experiences in the home environment is part of the unwritten or unspoken body, that which can not be definitively named. The burn is "matter in place" in the home, acceptable hardship and suffering, it is "matter out of place" in the clinic.[24]

In the domestic space women appear to have no language or vocabulary for discussing their subordinate position and the social disorder that they endure. They have adopted a medical vocabulary as an available language and have translated the combination of physical and emotional violence into bodily imagery, symbolic metaphors and complaints. This is signified through the power of medical technology as in the power of the injection that is a definitive guarantee against unwanted pregnancy, the power of the injection that can 'calm' the nerves and the 'salve and pain pills' that can heal the burn.

Towards the end of my fieldwork and in the writing up of this thesis I began working on a part -time basis in a health care clinic which offered Family Planning services. This afforded me the opportunity to reflect back on my fieldwork experiences. I mention this because what I came to discover was that there were many similarities. Many of the clients that I encountered did not know the name of their contraceptive pill nor injection. This was unrelated to their ability to decode texts as all had secondary education. Women who were on the injection similarly referred to it in

[24] This is not too dissimilar from Susanna's narrative.

temporal terms, the two or three monthly. It had likewise become part of their everyday language.

I noted that most of the women who were on the injection conformed to racial or gender stereotypes previously discussed. Three young women ranging from eighteen to twenty two who worked as 'escorts' or in casinos echoed similar sentiments. They stated that their lifestyles were not suited to taking a pill everyday as they had no routine, their hours were long and erratic and "no ways could they fall pregnant".

What I came to realize was that these beliefs were culturally embedded and that women made decisions depending on their social context and daily realities. They were not passive, unquestioning subjects of public health ideology, rather many women had instumentalized their own bodies in order to make necessary choices which were in accordance with their social context. They had recontextualized medical technologies and operative medical literacy. A woman who worked as an escort explained:

> I have chosen the injection because I can continue working with no interruptions as I do not get my periods, so I can work right through and decide when I need a day off. I also know it is a definite guarantee against unwanted pregnancies.

Thus the injection often has other social ramifications. This woman has learnt how to use her body or what Mauss has referred to as 'techniques of the body'. This reference to techniques of the body is relevant as Mauss examines body comportment or techniques in the context of everyday life practices.

> By techniques of the body I mean the ways in which from society to society men(sic) know how to use their bodies (1973 :70).

> The body is man's(sic) first and most natural instrument. Or more accurately, not to speak of instruments, man's first and most natural technical object, and at the same time technical means, is his body (1973:74).

4.9 Conclusions

The women interviewed have transcribed and re-embodied their gender experience in both the domestic and wider community spheres to medicalized vocabularies, technologies and spaces. Based on the symbolism of the open - closed body they have sought symbolic resolution for their gender related issues and other social interventions in medical procedures and metaphors. Certain medical interventions actually exacerbate these negative gender dynamics whilst other medical technologies are turned to for a resolution. This is an expression of cultural hybridity because these women have re- contextualized certain medical technologies and practices within the context of their everyday life practices. They have appropriated certain aspects of medical technology, the injection as a surety against unplanned pregnancies and symbolized it as having almost transcendent and mythological qualities. The injection as symbolic capital is invested with unequivocally powerful qualities allowing for a sense of freedom and self- autonomy.

Women divorce their bodies from the domestic sphere and relocate them in the medical sphere. The medical space is a safe space, a space of family and home (as discussed in the previous chapter). The Family Planning clinic can be viewed as a place or space where women are able to temporarily exit their broader realities including those of unemployment, crime, and domestic and social violence and where they have constructed a space of security and familiarity from within their own community margins.

The injection affords a certain amount of independence. By choosing the injection as a form of birth control these women have turned the medical gaze back onto itself. They relinquish their bodies to medical technology, yet through these actions they are able to free themselves from forced reproductive capacities. The rescripting of medical discourse thus occurs at the level of resistance, negotiation and mediation.

I have described moments of carnival and jocularity centred around events at the Family Planning clinic, yet in the context of the Baby clinic and treatment room I have talked about silence, passivity and tension. In the spaces of the treatment room

the 'ceremony of power'(Foucault,1979) is experienced at its most consolidated level. These contradictory moments have spatial ramifications, in that certain spaces represent specific forms of medical intervention. For example, immunization and the treatment of wounds are closely connected to silence and passivity whereas events outside the Family planning clinic are symbolic of carnival as previously discussed. In addition to these contradictory moments these spaces may also represent spaces in which processes of resistance and contestation occur. In all these instances the body becomes a relational nexus around which contesting signifying practices are enacted.

CHAPTER FIVE: CONCLUSION

Introduction

In this concluding chapter I provide a framework within which to 'read' my conclusions. Closure is arbitrary and frequently a measure imposed by time and space, in this instance it is a measure imposed by the academic institution and by the constraints of academic research. I provide an attempt towards closure accepting that it has been circumscribed by academic discourse and practice. I confirm the arguments suggested in the previous chapters and I offer some tentative suggestions for future debate and research commenting on the value of this research for health care initiatives.

Conclusions are derived from the process of reflection coupled with the interpretation and analysis of one's data and from experiences in the field. The findings are based on my interpretations of the data and provide differing ways of 'seeing' and 'reading' literacy while noting that this research is located within a particular historical conjuncture, situated within the ongoing transformation of post apartheid SA.

In the introductory chapter I presented the three initial research questions with which I entered the field site. These questions opened up a conceptual space within which to explore other forms of literacy. These questions were viewed in relation to events as they unfolded and developed . Furthermore, I realized that ethnographic knowledge does not remain static, rather it is transformed and reconstructed both in the field and in the writing process.

The questions were:

- If "illiteracy" is truly the "handicap" or "social disease" that certain development and modernization discourses would have us believe, why are literate patients not visibly engaging with texts ?
- Why do patients appear to become passive recipients of medical intervention once entering the medical space?
- And if so, how and why, are their literacy practices being delegitimated and marginalized by the medical discourses ?

This section presents a reflexive summary of the theoretical influences that have been drawn on in developing a conceptual framework for the research project and for providing the theoretical language for analyzing the research data.

I set out to study literacy practices, but found that in spite of patients' abilities to decode texts, they were not engaging with medical texts in the manner in which I had anticipated. The realization that both literate and non- literate patients were not visibly engaging with the medical texts, and that their literacy practices were perhaps embedded in other social practices required a re- examination and reformulation of my original research plans. This was not a linear process; instead I realized that I needed to approach my field site in a different manner requiring new modes of understanding and enquiry. This required a theoretical move towards understanding the body as a text, as it was here that I sensed a form of disjuncture and dissonance in the manner in which patients related to their own bodies , to medical texts and where the textual practices of the medical institution (of which medical technology played a crucial role), were most directly enacted. I also further extended the concept of medical literacy to include medical technologies and expert knowledge systems.

This broadening of the concept, by moving out of the realm of print literacy (alphabetic literacy and numeracy) to other and differing 'readings' of literacy, was a direct result of what I began to uncover in the field. I was perplexed as to what was happening once patients entered the medical space- that literacy practices were being translated into ways that did not conform to my previous understandings of literacy.

My theoretical constructs began to change and develop as a result of what I observed, and as I began interpreting the data.

The focus of this research project has been on social literacy practices and the manner in which acting subjects reinterpret and recontextualize their experiences of medical intervention in the form of medical literacy, technology and space. I have provided a study of the 'ordinary' and of the everyday life practices of the people living in the Hout Bay harbour community who visit the day hospital. I explore how people who are not part of, or who have no power in expert knowledge systems, respond to these structures in their daily lives and how they are interpreted and incorporated into their social order. These processes are often however fragmented and contradictory .

One of the values of this research project lies in the nature of the data collected. In studying the everyday life practices of those who are considered on the socio-economic margins, hidden voices have emerged. Through this process of '**local criticism**', '**subjugated knowledges**'(Foucault,1976) - buried, hidden and disqualified knowledges- are uncovered and placed in contradistinction to grand totalizing theories. Releasing subjugated knowledges through local criticism and bringing them into play, is important in developing a more comprehensive understanding of social reality. Grand narratives do not reflect the fragmented and diverse nature of social reality. Uncovering local knowledges thus becomes socially useful knowledge. It is through the re-emergence of these buried, disqualified and locally hidden knowledges that local criticism performs its work. Thus on the basis of a description of these local discursivities, subjugated knowledges are released and brought into play.

In the introductory chapter I reviewed the theoretical influences that had an impact on my epistemological development starting with the body of work developed within the NLS. The deconstruction of traditional constructs of literacy as an isolated technical skill, opened up the space for considering the existence of other forms of literacy those not strictly centering around reading, writing and print materials and led me to further engage with anthropological and social theories of the body. I thus further

extended ways of seeing literacy to notions of literacy as **embodied** and **embedded** within socially constructed space.

My work was informed by Street's (1993) and Baynham's (1995) concepts of literacy practices which firstly emphasized the social nature of literacy, and secondly, the multiple and often culturally contested and ideological nature of literacy practices. I then introduced the term social literacy which overlaps with Street's(1994) descriptions of local or vernacular literacies. Social literacies are socially embedded literacies that arise in response to a dominant discourse. I argued that in the context of the day hospital, patients through their own literacy practices, rescript dominant medical literacies and technologies to suit their own health and local needs within the context of their everyday life practices. Uncovering this process, whereby patients are able to recontextualise their experiences of medical literacy and technologies in the context of their material and social realities is one of the key arguments of this thesis.

In Chapter Two, I began by providing a narrative description of the place and the texts encountered, the manner in which they are discursively constructed within various discursive domains. I then proceeded to explore and uncover the 'hidden texts'. I argued that texts are always located within particular social contexts and that understanding literacy involves studying both the texts and the practices surrounding the texts. In a social literacy approach, texts and literacy practices are inextricably intertwined. However, in my findings they were not always linked. The texts that were available were removed from social context and were often written in language inaccessible to most clients. They formed the 'walls' of the institution but little else.

This led to the suggestion that the encoding and decoding of texts was not the central issue. Rather, patients had through practice and through their own local interpretations of medical texts, decided what they needed to know and when they needed to utilize their reading and writing skills. What was more important was not being able to engage in mainstream alphabetic literacy as reflected in their response to reading labels on medicines bottles, reading pamphlets or 'informative' posters, rather it was how patients used their own socially embedded literacies to mediate and

gain access to health care entitlements and treatment and the discursive skills and resources that they employed in order to do so. I introduced the terms 'culture of entitlement' and 'working the system' as they began to explain some of the dynamics at play and the hidden literacy practices.

In Chapter Three, I explored the manner in which literacy is constructed and constituted within and through socially constructed space. I argued that the day hospital is not merely an institutional construct, but a socially constructed space that has symbolic meaning for many of its inhabitants. Through the narratives recounted by staff and patients, I indicated how spatial dichotomies of inside and outside, formal and informal, merged to form in certain instances integrated community space. I set out to show how the boundaries between formal institutional space and informal community space were reconstructed resulting in a hybridization- a reclamation of the clinic space as community space. I drew on Bakhtin's (1968) depictions of carnival to illustrate this point, how through moments of carnival patients were able to resist the dominant social order.

The hidden texts were the way in which patients rescripted or recontextualized their experiences of medical literacy and technology so as to create an environment that was more integrated to their material and social realities. Thus, whilst patients did not appear to directly engage with medical texts, they had transcribed their experiences of medical objectification into their own social order and through a process of hybridization had created their own space. Out of place they had created space, a space of familiarity, family and 'home'.

I discovered that patients were not passive recipients of medical intervention. I explored the social practices, centering around the notion of the 'culture of entitlement' and "working the system" as it further enhanced my understandings of the ways in which patients were able to rescript their experiences of medical intervention and treatment. These innovative social practices were frequently overlooked or underplayed by the medical staff.

In Chapter Four, I extend the spatial analysis of the previous chapter to explore the manner in which the body in the medical space is symbolically spatialized through the textualizing processes of induction into the day hospital, and secondly, how these textualizing processes metaphorically compartmentalize the body into spatial components. The body is conceptualized as a cultural text which is inscribed and made meaningful through the operation of contesting signifying practices. Foucault's concepts of the disciplined and morally regulated body and technologies of inscription provided a frame and point of reference to initially uncover the textual dynamics at play. They did not however allow for notions of human agency nor resistance. My central focus was on the women attending the Family Planning clinic and I discovered that they were placed in a contradictory position. On the one hand they experienced a sense of self-autonomy over their reproductive processes, yet on the other hand, they relinquished their bodies to medical technologies. This became a further expression of cultural hybridity. These women had re- contextualized and re-embodied certain medical technologies and practices that impacted on their experiences within both the medical and the community or domestic spheres.

The transition from the carnival atmosphere in the corridors and waiting room, to the passivity and silence of the treatment room, continued to mystify me. However, I came to recognize that in all these instances the body became a relational nexus around which contesting signifying practices were enacted.

I realized, in returning to my original research questions, that if I continued to work within the theoretical paradigm that I had initially constructed, literacy practices would remain 'hidden'. While patients might not visibly be engaging with medical texts and medical literacies they were engaging in ways that were embedded within other social practices. They were in many instances, re-translating and re-contextualizing their experiences of medical intervention in diverse and often contradictory ways. On the one hand, they were dependent on the system for medical entitlements and treatment, yet on the other hand, they were able to rescript dominant medical literacies and technologies within the context of their own personal and social needs.

Literacy practices might not be visible in the form of reading and writing, but it can be argued that patients have refashioned and rescripted expert medical knowledge and literacies, not only for their own understanding of illness and dis-ease, but also for extra-medical purposes such as welfare entitlements, access to medical resources and in the creation of spaces of communal activity.

Throughout my research and as reflected in the summary of findings and conclusions drawn, I was able to identify certain processes that occurred. It was at the interface between the formal as represented by the medical institution and hence medical literacies, and the informal, represented by the larger community and patients from within this community, that diverse literacy practices were located. The rescripting or re-contextualization of literacy thus occurred at the level of negotiation, mediation and conflict.

Street in the preface to the forthcoming SoUL book has asserted:

> Seeing literacy as not just a single unitary phenomenon attached to formal education institutions but as a variety of social practices, is such a new and challenging approach that the researchers have found themselves subject to intense critical scrutiny (In ,Breier& Prinsloo (forthcoming) preface: i).

A possible criticism is that my conceptualizations of literacy - removing reading and writing from the process- have deconstructed the concept so as to leave little of substance or specificity. I argue that broadening of the concept was a necessary undertaking. Discursive practices are dispersed and meaning is neither stable, nor fixed. Specificity, frequently employed as a positivist construct , makes the assumption that there is a fixed definition over meaning thus not allowing for movement or dispersion.

Encountering the social world of informants through ethnographic research methods and processes led to my experiencing the field in diverse and unpredictable ways.

Gidden's(1982) concept of the **double hermeneutic** was particularly useful at this juncture. The double hermeneutic enables one to examine the ways in which social science(or research) enters the lives and activities of the subjects of interpretation. But at the same time, in order to examine the world of others, one is also examining and reflecting on one's own world. Thus hermeneutics enters social science (research) on two related levels, one being the social world of the subjects that one is studying, and the other is the world of the research itself.
I recognize the dialectical relationship between the field and research(data and theoretical constructs developed) and the everyday of both researcher and researched. In studying the everyday, the ordinary and informants' life worlds I discovered that these processes were similarly impacting on my own practices, both in the academic research process and in my professional work environment .

In the light of the foregoing research project I would tentatively suggest that future health care initiatives need to take cognizance of patients' own literacy practices, their existing cultural understandings of their bodies, health and dis-ease.

Comments and reflections: Implications for health care initiatives
Despite references in academic and public discourse to different kinds of literacies - computer literacy, functional literacy and media literacy - there is still little discussion around the notions of local literacies. In the current restructuring of the post apartheid health care system, equitable distribution of health care resources and primary health care are the major foci. I argue that these emphases need to explore and take cognizance of patients' existing expectations and understandings of medical literacy and technology rather than imposing a monolithic system.

In the same way that recognition is now being given to 'traditional' or 'indigenous' healers, patients' own values systems and cultural receptions of health and of the medical system need to be uncovered, taken into account and included when decisions relating to future health care provision are made. We thus need to recognize local and subjugated knowledges remembering that the marginalized have their own understandings of the health care system. If we fail to recognize the diversity of

experiences and the cultural constructions of others, providers of health care services in SA run the risk of reifying particular cultural 'others' and labeling them as quaint and exotic. It is necessary, therefore, to explore the multiple and varied ways in which medical intervention and practices impact on local communities because they recontextualize their experiences in diverse ways, that do not necessarily correlate to particular cultural or ethnic groups' indigenous practices; instead, the cultural penetration of medical discourses into peoples' everyday social practices and life spaces are often expressed in the form of a cultural hybrid.

Processes for exploring and uncovering the multiple and varied ways in which patients' internalize and comprehend medical texts have been highlighted in this research project and it is suggested that in developing suggestions and recommendations for future health care initiatives, similar processes be used in developing and understanding subjugated knowledges. These processes have included translations at complex levels. One of these relates to the translating and transcribing of interviews from Afrikaans, the local vernacular, to English which is often associated with medical authority and literacy. In addition, I alluded to the difficulties I experienced in exploring how the nuances of meaning were frequently lost in translation, but I attempted wherever possible, to maintain and capture the resonances and symbolic meanings behind the language. Patients' translations of alphabetic and medical literacies were frequently reconstituted within metaphorical or symbolic language, which in turn, was embedded within everyday language.

In the same way that the meaning inherent in patients' everyday language was translated and reconstituted through the research process, it is suggested that the medical texts (in the form of posters, pamphlets and medicine labels) be translated into the local vernacular or in ways that patients are able to access and derive meaning from these, within their own cultural contexts. Despite texts being available and staff members' frequent references to the need to have more time to educate and teach patients, the intended pedagogical material did not appear to have any direct impact and I rarely witnessed patients engaging with these texts .

Although AIDS is increasingly a serious health problem in SA and although attempts, however contentious, have been made to address this problem, AIDS was never openly discussed by informants or by the staff. The only allusion to AIDS was in the form of visual display (posters) and a reference to " two known HIV positive clients", in the Community Profile of 1994. Furthermore, the cultural constructions around condom use in the context of safe sex practices was not addressed or explored and, once again, patients did not engage with the available materials or texts. I argue that unless these issues are highlighted and taken into consideration in terms of patients' own cultural constructions and local understandings, health care information will remain on the level of display and medical literacies will not be translated into the everyday experiences of the recipients of health care.

APPENDIX 1

QUESTIONNAIRE : FAMILY PLANNING CLINIC
Hout Bay Day Hospital.

1. What method of family planning are you taking? The Pill or injection?
2. What is your age?
3. How many children do you have?
4. Are you planning to have any more children ?
5. Do you know the name of the pill that you are taking?
6. Do you know the name of the injection that you are taking?
7. How often do you come for injections or for the pill?
8. Do you remember what your weight or blood pressure was?
9. Are you experiencing any problems with the pill or injection?
10. How often do you visit the family planning clinic?

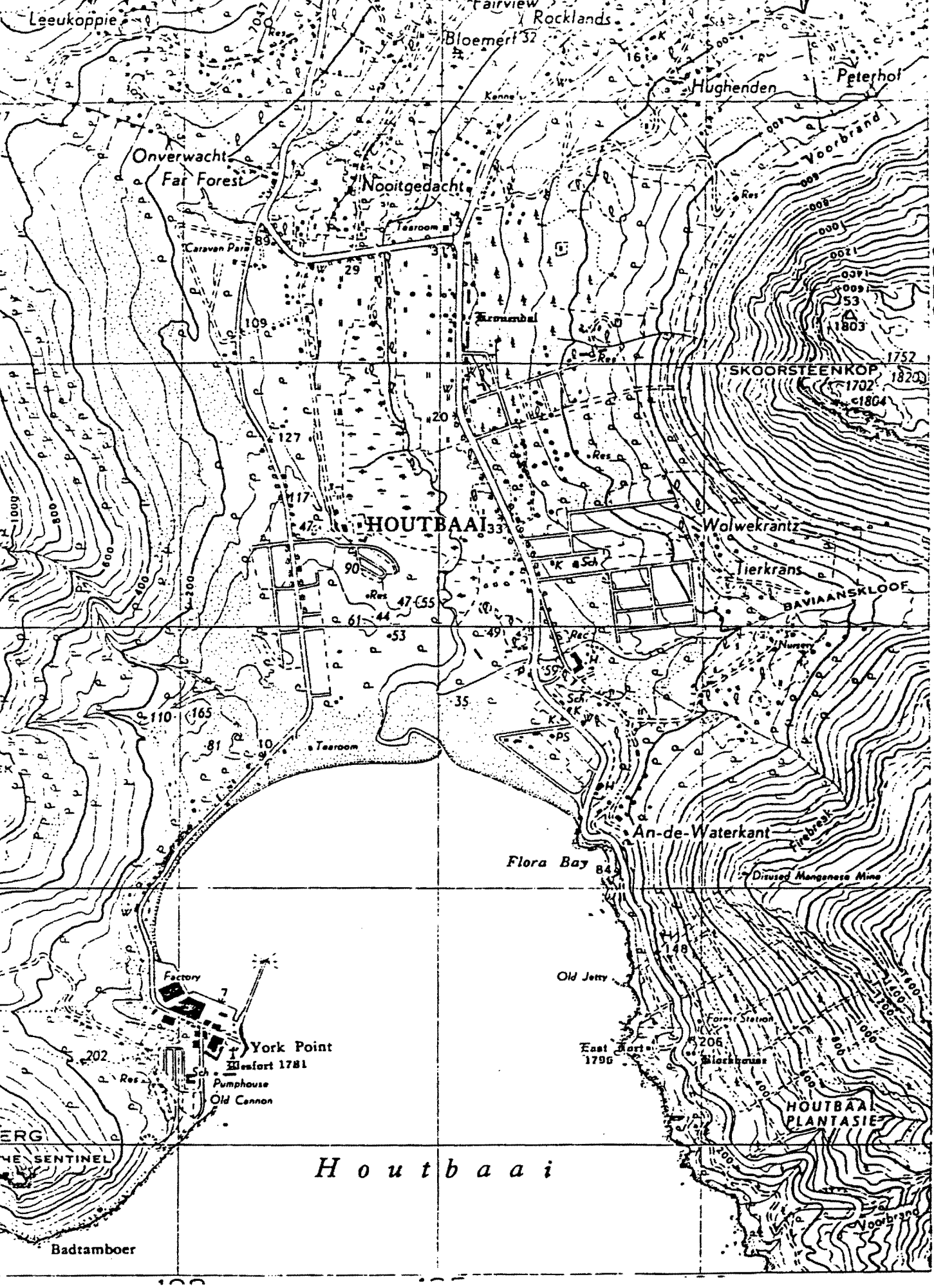


FIGURE 1

18°-22°

TOPOGRAPHICAL SURVEY SHEET No 2780

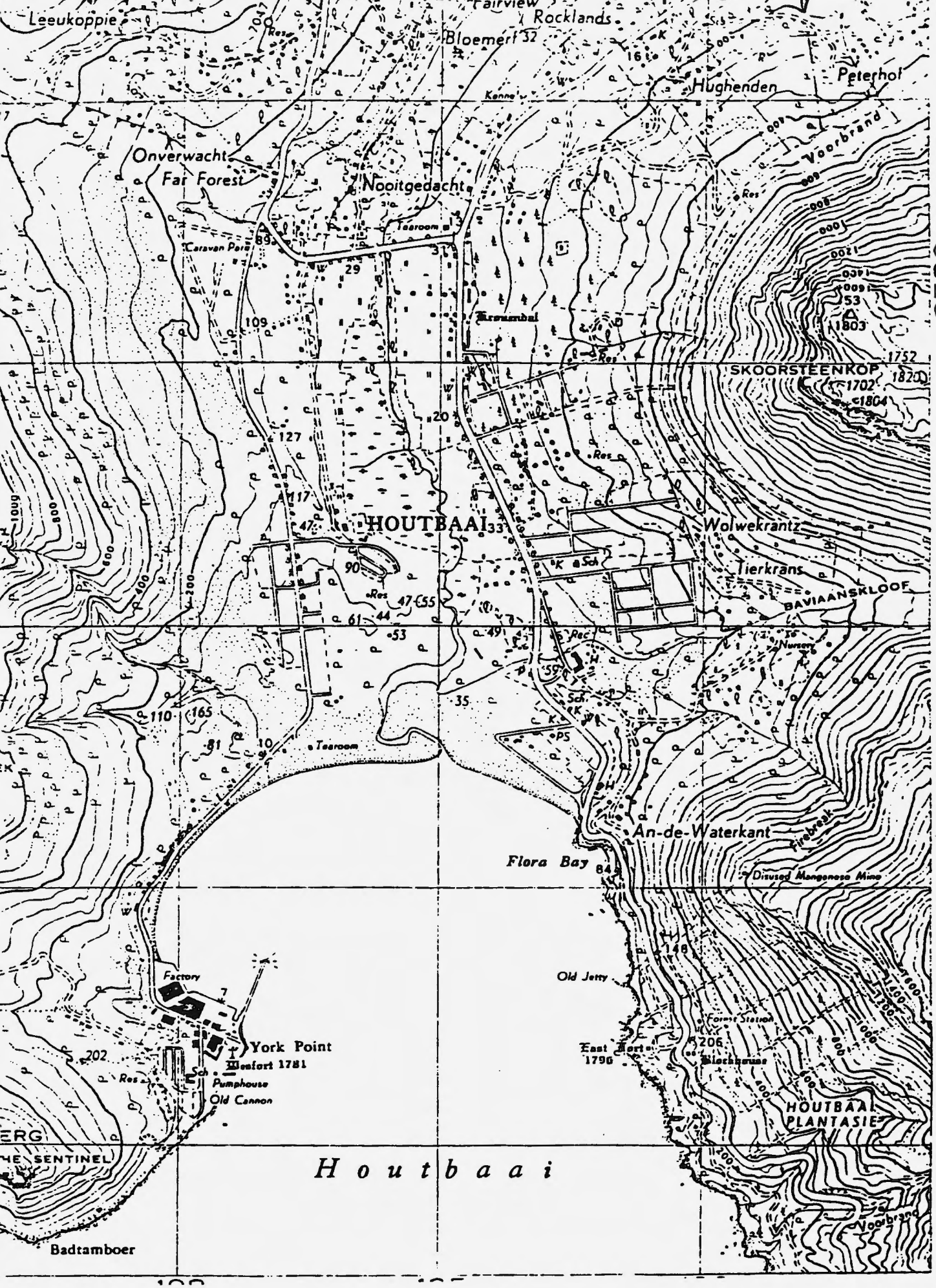


FIGURE 1

18°-22°

TOPOGRAPHICAL SURVEY SHEET No 2780

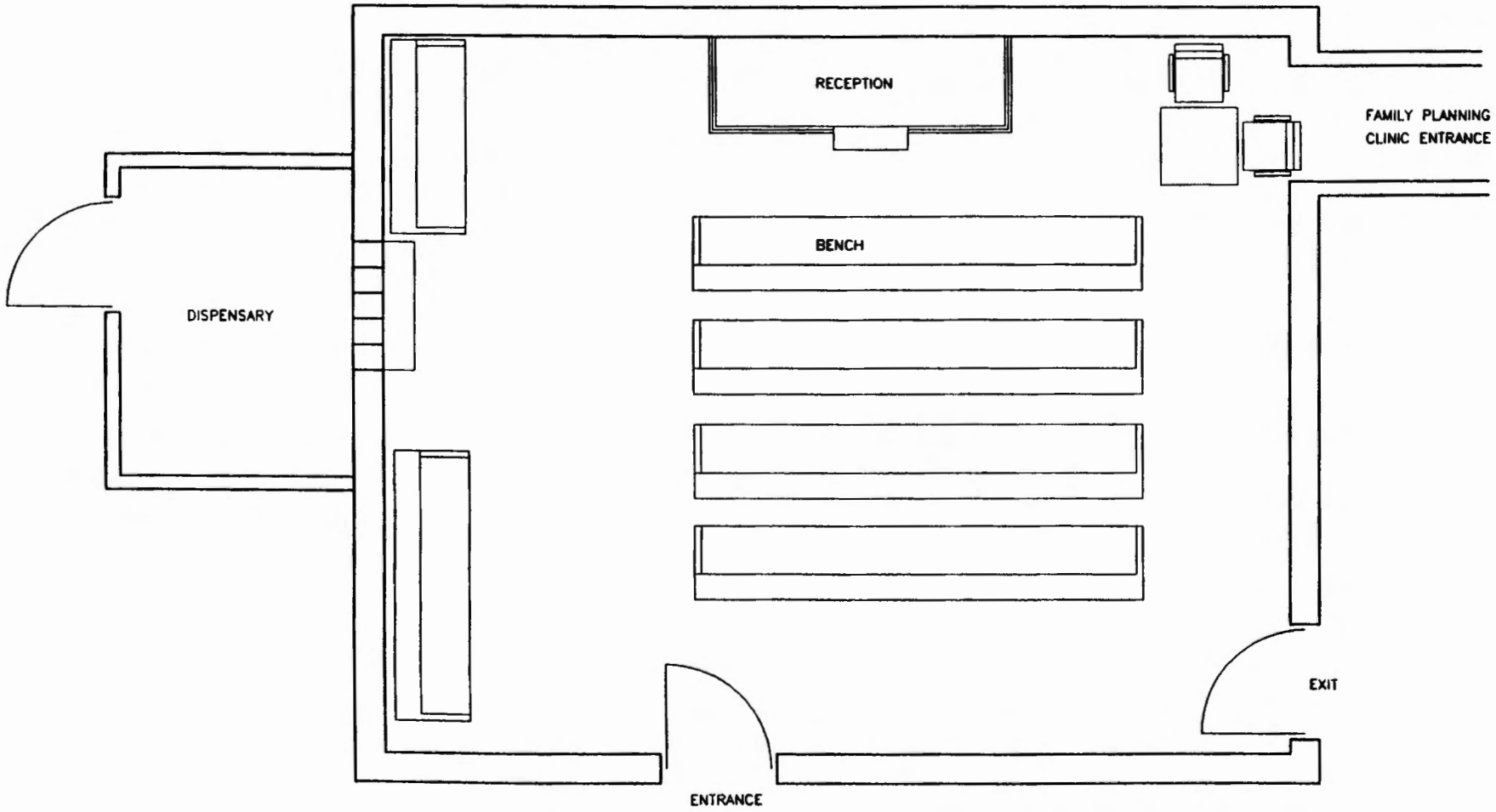


FIGURE 2: Waiting Room

FIGURE 3: Baby Clinic

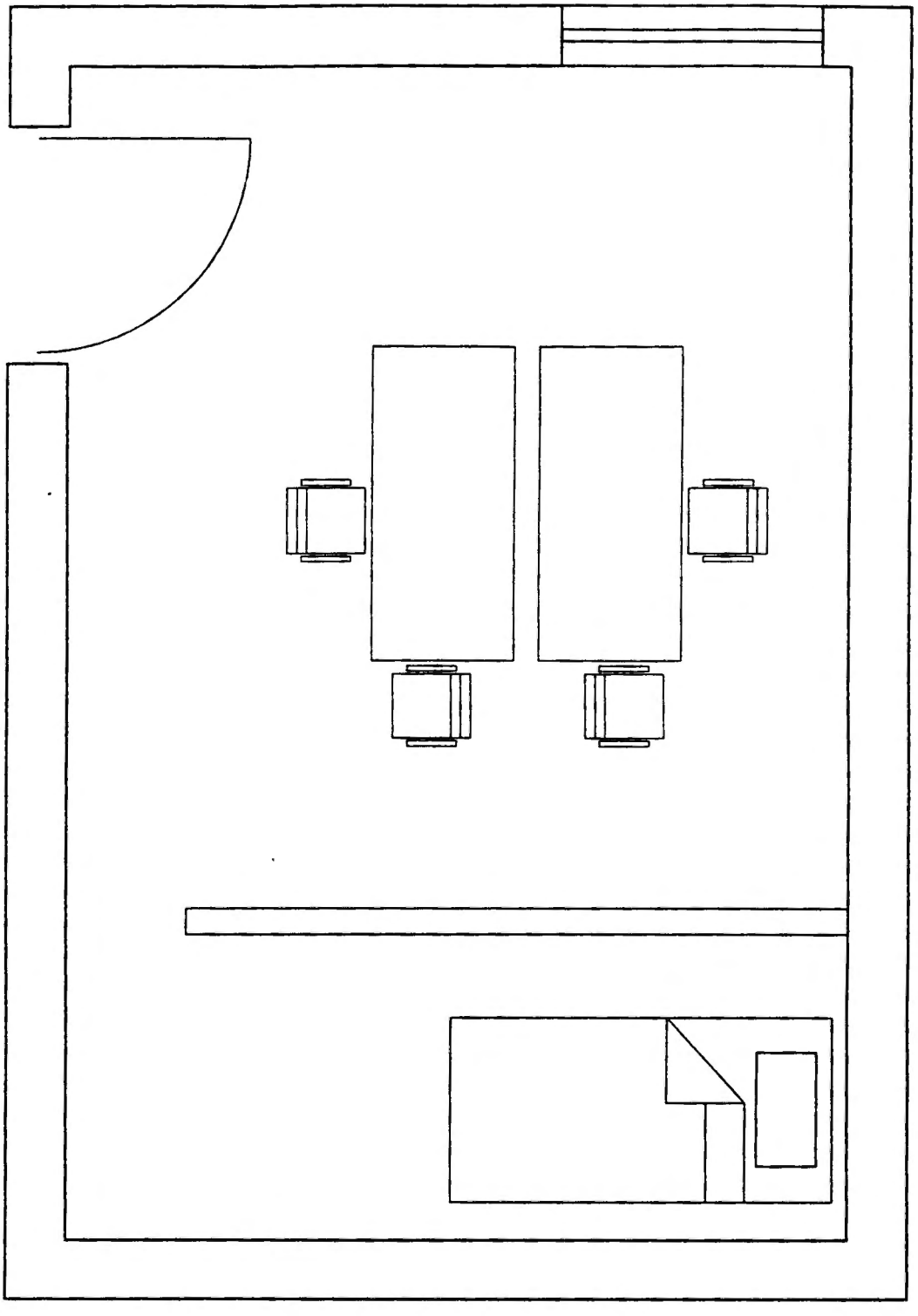
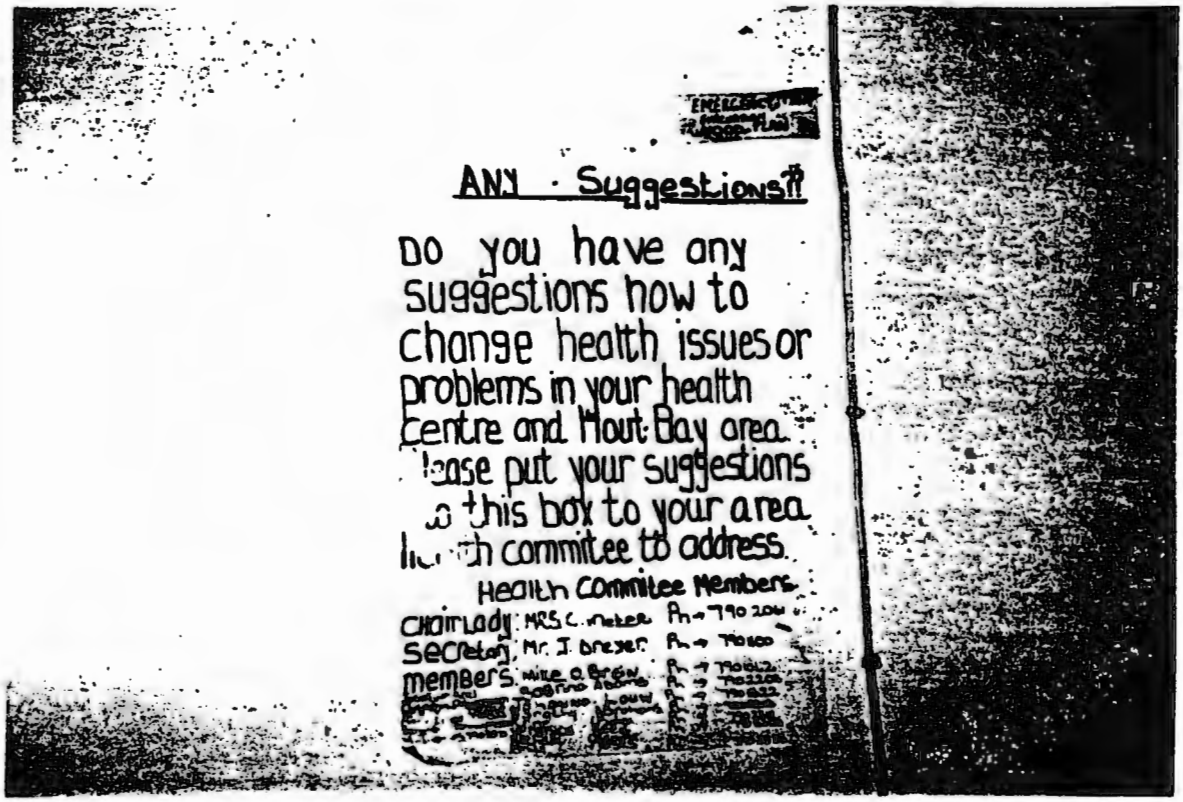


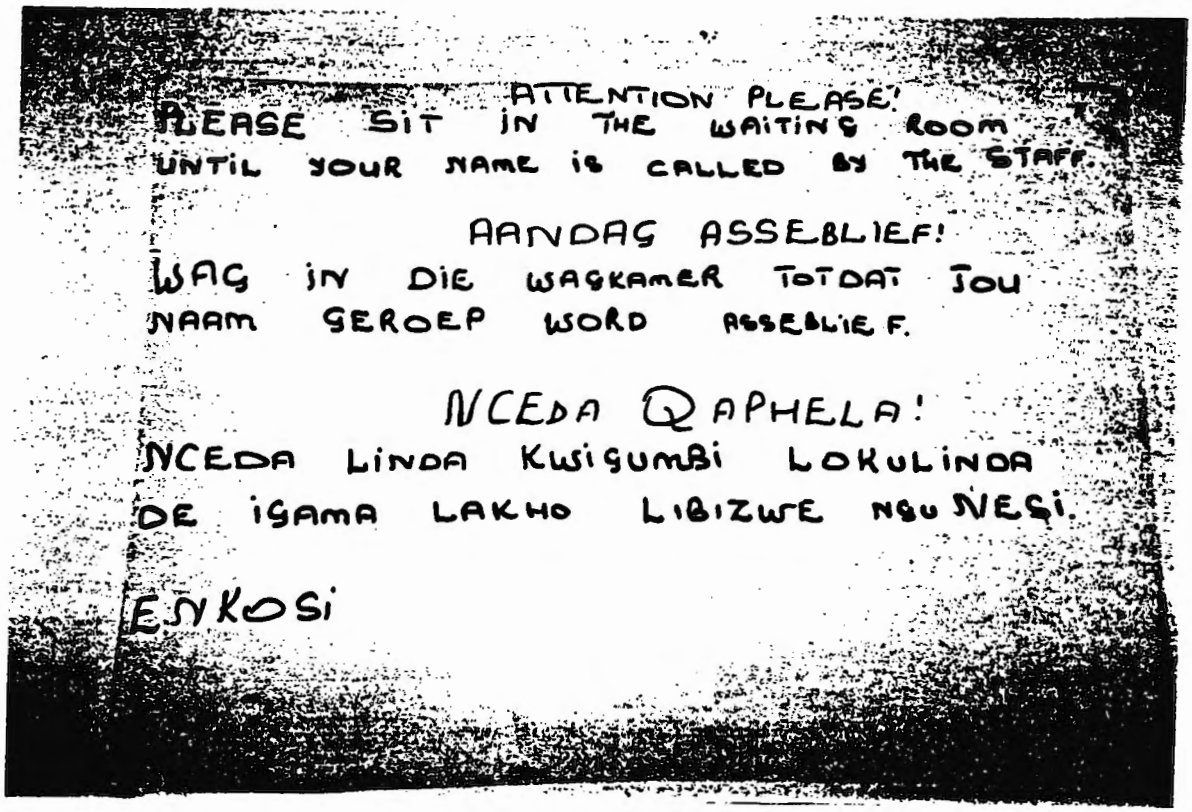
PLATE 1 : General Optical & Health Suggestion box



HEALTH SUGGESTION BOX

GENERAL OPTICAL

PLATE 2 & 3: Signage in the Reception Area



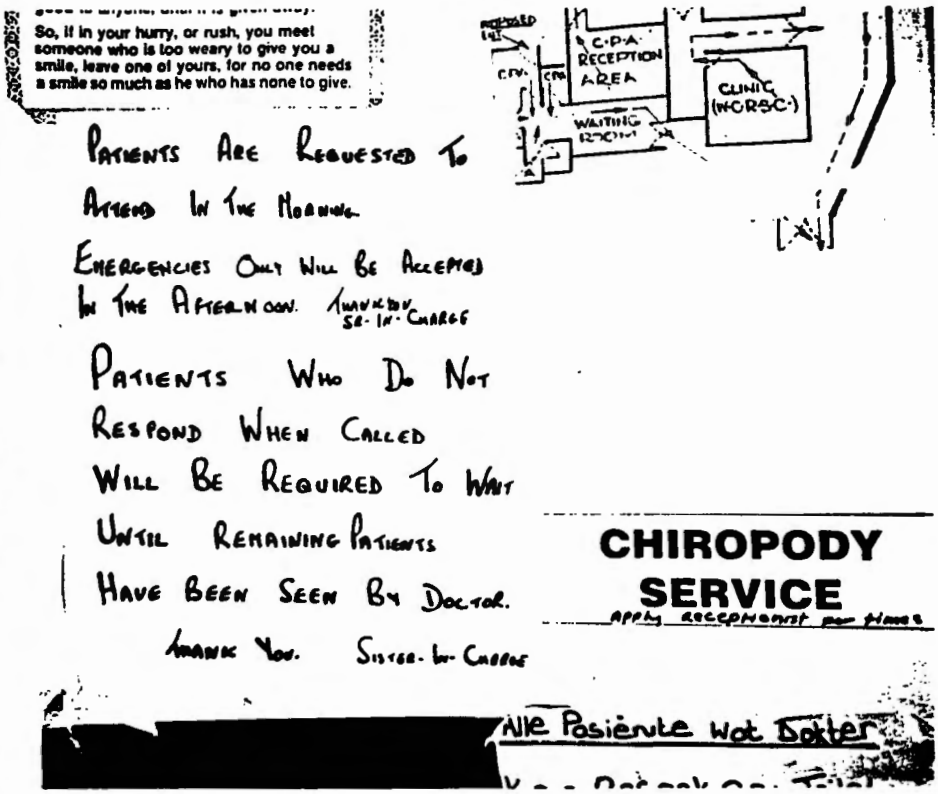


PLATE 4 & 5

DANGERS

PLATE 6

SAFE SEX & CONDOM COLLAGE

PLATE 7

BOX OF CONDOMS AT RECEPTION

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