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1. CONSTRUCTION OF THE RESEARCH OBJECT: WOMEN'S LITERACY AND REPRODUCTIVE HEALTH CARE PRACTICES IN THE HOUT BAY DAY HOSPITAL

1.1 Introduction

This research project explores the relationship between women's literacy and reproductive health care practices¹ within a specific setting, the Hout Bay Day Hospital and its environs. In this introductory chapter, I shall outline my construction of the research object. This study began as an analysis of literacy practices amongst women attending the Hout Bay Day Hospital, the manner in which these practices intersected with the dominant discourses of medicine and its attendant technologies, 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 a 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?
- How and why are their literacy practices being delegitimised and marginalised by the medical discourses?

The realisation 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 traditional conceptualisations and understandings of what it means to be literate. I thus needed to approach the field site in a different manner requiring new modes of understanding and enquiry. This required a discursive move towards understanding the human 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 and experienced.

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.

1.2 Theoretical and Methodological Influences

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 analysing the research data obtained in the field. The theoretical influences will be discussed separately, firstly literacy and then reproductive health.

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 Studies², which has led to the deconstruction and subsequent reconstruction of the 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 1994) 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, using the works of Street in Anthropology (1984; 1991; 1993), Brice Heath (1983) and Gee in Sociolinguistics (1990), Barton in ecology of literacy (1994), and Baynham in literacy practices and literacy mediation (1995).

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 a major influence on this research project and the bedrock upon which I placed my ensuing epistemological developments.

1.3 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 Sociolinguistics, Anthropology, Psychology and Education.

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".

Furthermore, 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: "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).

Heath's classic *Way with Words* (1983) 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, on the other hand, extended the concept of literacy event to literacy practices which include 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.

1.4 Discourse and Literacy

Gee, a sociolinguist, takes the notion of literacy one step further when he develops a definition of literacy which embeds it in Discourse (with a capital D). Thus he writes: “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 organisation 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 organised 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.

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).

Gee's distinctions between acquisition and learning are important in terms of the experiences of people attending the day hospital. In this setting, 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.

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 utilise differing communicative codes depending on the context.

Foucault's perspective on discourse is an important influence in this study and on many NLS theorists. Foucault (1972) takes the concept of discourse 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.

1.5 New Literacies

Street (1998) has recently elaborated on his initial concept of literacy practices to include various communicative practices. This is achieved by exploring the micro ways in which people deploy linguistic resources, including how they link communicative practices from one domain, such as literacy, with those of others such as visual images. He discusses how people employ various semiotic resources in creative and independent ways.

Breier and Sait (1996) have shown how in the Western Cape, apparently "illiterate" taxi drivers are able to get around the city by utilising a variety of semiotic devices including symbols, shapes, colours and memory. Likewise, even if one has literacy skills one might use other communicative channels in which literacy plays a minor role. Street (1998) by way of example, states that when he catches a train to London, for logistical reasons, he does not read the display board at the end of the platform, but instead identifies his train by its internal layout, colour and design. Similarly, in the day hospital and in the family planning clinic, many of the women who are literate identify the contraceptive injection by its temporal capacity and pills by its colour, shape and size.

1.6 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 conceptualised as products of culture, history and discourse. She thus defines literacy as “a set of social practices using a technology of inscription” (1995, 8).

Kapitzke’s conceptualisation of literacy as technology of inscription is relevant to both the research project 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 human body. In attempting to explore and understand the varied and complex literacy practices at the 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 textualising process of the institution. The apparatus of writing constituted the individual as a describable, analysable object; a case to be judged, measured, and compared with others (Foucault 1979, 191). Thus in the day hospital the patient’s 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 specialised 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.

1.7 Social and Local Literacies

In contradistinction to standardised 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 organising power over peoples’ lives and begin to colonise their everyday life spaces. What I call social literacy arises in an attempt to decode dominant alphabetic literacy; to decode the world that is reorganised 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.³

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.

Medical literacy and technology as part of mainstream alphabetic literacy, base their legitimacy and authority on being socially decontextualised 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 recognise 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 and personal needs. In this process, medical literacies take on meaning within the context of people's everyday life worlds. 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 recontextualised from one form of literacy to another.

1.8 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. 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 (1996), 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 normalising gaze of institutional power and social control, whereby literacy mediators play an important socialising 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. 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 reconceptualisation 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, conceptualising 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.

1.9 Reproductive care literature review

The literature review will consist of three related areas; medical anthropology, more specifically theories around the body; the anthropology of gender, and local studies of reproductive health care.

Paralleling the manner in which the New Literacy Studies challenges political and cultural neutrality of literacy technology and development theory, medical anthropologists also question the acceptance of biological and biomedical data as an assemblage of incontestable natural facts (Lindenbaum & Lock, 1993).

In medical anthropology, medical or scientific knowledge is not necessarily the starting ground for analysis, rather there is a convergence of other discourses at play.

This perspective views all knowledge of society, sickness and the body as socially and culturally constructed and explores how medical facts are assembled and

legitimized through medical discourse, care-giver/ patient dialogues and interactions, and by wider social and political institutions. Thus the medical anthropological perspective examines the social conditions under which knowledge is produced (Young 1982; Good 1994). Furthermore, medical anthropology seeks to move beyond the monological discourse of the medical establishment to examine how experiences of the body, disease, illness, sexuality and reproduction emerge at other social sites external to, but interacting with, medical institutions and practices (Martin 1989; Kaufert & O'Neil 1993, 1995; Ginsburg & Rapp 1995). These frameworks imply that gender and reproductive health cannot be treated as pre-given cultural facts but are rather subjected to ideological mediation and norms.

Haraway (1991) challenges certain taken for granted assumptions about scientific knowledge arguing that we need to recognize internal contradictions and variations within biology itself. This is particularly useful as medical anthropologists tend to in their critique of the biomedical paradigm overlook internal contradictions within these very establishments.

Martin (1989), in providing a cultural analysis of reproduction, has explored the performative and discursive construction of the female body in the medical treatment of menstruation, childbirth and menopause and demonstrates the extent to which wider metaphors of economic production current in American modernity have infiltrated medical discourse and perception.

Crucial to the study of the social formation of medical experience and understanding is the concept of cultural performance in which both the body and the treatment space are understood as theatres and rhetorical stages upon which wider social narratives such as gender norms and development agendas are materialized and made real. This framework is crucial to examining the mode of transfer of medical knowledge from care-givers to patients and in uncovering the autonomous ways in which medical norms are rescripted by patients in response to wider social forces and pressures. In turn, the performance model enables one to show how the treatment or clinic space is not isolated from wider social forces, but is penetrated by the latter and transformed into a space into which broader social conflicts are metaphorized and symbolized (Kleinman 1980; Farmer 1988, 1990; Scheper-Hughes & Lock 1991).

The work of Foucault (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's tenet that the language of biomedicine is produced through discourse creating its own objects of analysis, has had a profound influence on how both anthropologists and sociologists have approached the human body and biomedical categories such as disease, illness and risk (Turner 1987; Martin 1989; Lock & Scheper-Hughes 1990; Feldman 1991).

Ethnographic works, by paying close attention to the everyday lives of women and their wider familial structures, has led to a re-evaluation of anthropological theories around the body, and more specifically, for purposes of this study, around the gendered body. For medical anthropologists, the term resistance has served to bring

attention to cultural forms and activities which resist the increasing medicalization of our lives and thus of the encroachment of hegemonic cultural forms (Good 1994:58).

The concept of resistance has also been used to analyze forms of illness experience and bodily dissent, more commonly studied as “possession”, “hysteria” or “somatization” (Lock 1993; Good 1994). By way of illustration, Ong (1988) analyses attacks of “spirit possession” on the shop floor of multinational factories in Malaysia as part of a complex negotiation in which young women respond to violations of their gendered sense of self, difficult work conditions, and the process of modernization. Similarly Boddy (1989), in her study of Muslim women in Northern Sudan, explores the apparent contradictions between the cultural construction of women according to the male dominated Islamic derived ideology, and the cultural productions of the women themselves, manifest largely in ritual and narrative associated with the Zar cult or spirit possession. In trance, however, it is possible for women to create a reflexive, counter-hegemonic discourse that permits women to re-negotiate their sense of self. Seremetakis (1991) in her study on women in rural Greece, is similarly concerned with identifying strategies of cultural resistance that emerge and subsist on the “margins”. These are expressed emotively through diverse social practices such as death laments, mourning rituals and divinatory dreaming.

The body imbued with social meaning, thus becomes not only a signifier of belonging and order but also an active forum for the expression of dissent and loss thus ascribing it individual agency (Lock 1993:141).

Linked to notions of resistance is Weiner’s (1976) study on exchange in the Trobriand Islands. Challenging Malinowski’s seminal works on the Trobrianders, and through foregrounding women’s pivotal roles in exchange networks, kinship structures and mortuary ceremonies, she explores how women operate in differing domains of power and demonstrates how power is not necessarily located in the political sphere. Cultural power is thus often located in unexpected places.

Recent feminist scholarship⁴ has been attentive to the multiplicity of social relations that structure women’s identities in interdependent and contradictory ways. Post-colonial feminist theorists such as Spivak (1988), Mohanty (1988) and Minh-ha (1989) have asserted that “under Western eyes, the woman -native- other category tends to homogenize Third World women”. The experience of being a woman is different dependent on how one is positioned in terms of race, class, ethnicity, age and religion. Thus as a contested domain and a negotiable social process, gender is frequently fragmented, contradictory and multi-faceted.

Feminist theorists have also challenged the manner in which medical knowledge and scientific discourse encodes dominant representations of gender and of women⁵. Related to this, feminist theorists have attempted to demonstrate that gender is socially constructed and not a biological given. In addition, they have challenged the notions of sex, gender and sexual differences as being fixed binary categories (Moore, 1994), thus providing an important theoretical framework for

reconceptualizing asymmetrical gender relations and experiences of embodiment, and the manner in which gender and sexual relations are constructed and contested in diverse social settings.

Anthropologists working in the field of reproductive health have provided important insight into the manner in which reproductive technologies and ideologies are rescripted and adapted by local communities and the manner in which social experiences of reproduction and sexuality are historically and culturally negotiated, constructed and located.

Ginsburg and Rapp's (1995) collection of studies on the anthropology of reproduction challenges traditional anthropological analyses of reproduction, by exploring the manner in which reproduction is structured across social and cultural boundaries at both local and global intersections. Using reproduction as an entry point in the study of social life, and placing it at the centre of social theory, the authors examine how cultures are produced, contested and transformed as people imagine their collective future in the creation of the next generation.

Kaufert and O'Neil (1993,1995) and Fraser (1995), explore the complex and ambiguous effects of state intervention into local, community based birthing practices. They explore how local communities both resist and embrace medicalization and efforts to impose state mandated public health care policies. This is of particular relevance to the South African context where state health care policies concerning reproductive health care practices and rights are being redefined and implemented. These studies further illustrate the need to take cognizance of local perceptions and cultural practices.

Ethnographic studies around women's reproductive practices in such diverse settings as Nigerian women's conflicting responses to the introduction of contraceptives (Olu Pearce,1995),cultural understandings as they relate to pre-natal screenings (Rapp, 1993), women's resistance to the Romanian state's banning of abortion and contraception during Ceausecu's reign (Kligman 1995), and the impact of the new reproductive technologies, such as fertility enhancement, on traditional kinship structures (Strathern 1995), offers a further means to engage in conceptualizations of power in relation to the introduction and importation of reproductive technologies and ideologies into local communities.

Similarly, Lowenhaupt Tsing (1993), in her study of the Meratus people in an isolated mountainous region of Indonesia shows how people who we assume are situated on the "margins" of society are often affected by issues of modernization and globalization and in turn challenge and reinterpret these intrusions. Thus in even the most "out -of the- way- places" heterogeneity and trans- cultural dialogue exists.

However, despite this research, a paucity of detailed ethnographic studies from within a South African perspective remains. There are various epidemiological research projects underway, however, most research remains located within biomedical and epidemiological paradigms. The need for cultural awareness has

been identified locally, notably Planned Parenthood's peer education and training programmes and within my fieldsite,⁶ yet to date, there is virtually no medical anthropological input into these research processes and anthropologists within South Africa have given little attention to women's reproductive health care practices with the exception of Wood, Maepa & Jewkes' (1996,1997) qualitative studies on adolescent sexuality and contraceptive experiences.

1.10 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.⁷ 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.

There were a number of reasons for choosing this particular research site. One of these was my previous experience as a professional nurse. My knowledge of the daily functioning of a hospital helped me in my choice of a particular field site.

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 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.

Numerous changes have occurred over the past eighteen months, this is linked to the restructuring of the health care services in South Africa, more specifically, the emphasis on public and primary health care. This has led to a more marked separation between the medical section and the family planning and mother and child health section. The medical section deals mainly with chronic medical conditions such as diabetes, asthma, epilepsy, hypertension and more recently the rising incidence of STIs and HIV \AIDS within the community. All acute medical cases are referred to the larger nearby hospitals. The mother and child care section which includes family planning services and ante and post natal care, now appears quite separate, though located within the same building. Recently TB treatment has been included in the mother and child health care section. The latter section falls under the Southern Peninsula Municipality which forms part of Community Health Services whereas the medical sections falls under the Provincial Administration of the Western Cape.

Maternity services are provided free to all women and their babies up until the age of five and has been integrated into the new restructured primary health care system. Obstetric services in SA vary widely from meeting first world standards (in many

private and academic hospitals) to being almost non-existent in state services (in rural and poor urban areas) (HST Update 1998:5). However, in the case of Hout Bay the situation is somewhat different.

I have detected a tension between the medical section and the family planning section, largely due to the fact that the nurses in the medical section feel that they have a greater patient load whereas the mother and baby clinic is better staffed and has fewer patients. The nurses in the latter section have also managed to establish more regular hours for consultations and visits though technically there are no longer fixed times for family planning and mother and child health care services. Since the majority of the mothers are from the harbour community language barriers do not exist, whereas many of the patients in the medical section are from Imizamo Yethu squatter camp⁸ and translators are frequently required. Tension has existed over which section should be treating the large number of STIs and AIDS patients. The nurses in the medical section feel that the STIs should be treated in the family planning clinic whereas the nurses in the mother and child clinic feel that many of the cases are men and not linked to family planning or maternal and child health and this could cause many patients to seek help elsewhere. In the past two months those patients diagnosed with STIs and HIV and from Imizamo Yethu squatter camp have been referred to the Main Road clinic situated adjacent to Imizamo Yethu squatter camp. The situation remains fraught with problems and will be discussed in Chapter Four.

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 my access into the fieldsite was affected by racial and gender considerations. I was repeatedly advised by the nursing staff that it was inadvisable to go out alone into the community. I was informed of the increasing crime rate and the activities of gangs in the neighbourhood. Despite this, to date, I have encountered no real problems. Perhaps because I have always been accompanied by someone from the community especially when walking the streets or going on home visits.

1.11 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 experience as a nurse, to distance myself from the research object as well as to consider my relationship to it.

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 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.

1.12 Relation to the research object

The concept of self reflexivity, which I argue is integral to an ethnographic study, relates to my own experience in the field.

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).

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.

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.

Feminist anthropologists have explored the role of gender in anthropology and how it impacts on ethnography and fieldwork (Callaway 1992; Bell, Caplan & Karim 1993; Moore 1994). 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. 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 impacted on the manner in which 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 gendered discourse. Typified in an informant’s response.

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 woman, 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 various 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 or family planning advice. I also joined the local Hout Bay Health Forum to familiarize my self with community initiatives and health related activities.

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.

It was through the medical gaze and their perception of my position within the medical domain, that many of the women 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.

1.13 Data collection

One of the effects of undertaking 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 and reproductive health care practices.

I found that identifying key events (see Geertz on Balinese cockfight)⁹ 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 Mother 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 these visits over a period of eighteen months, in which I interviewed patients in the waiting room, women attending the Family Planning and Mother and Baby clinic, the Nursing Sisters and doctors and in

various sites beyond the clinic such as the Disabled group, Hangklip Seniors Club, women who worked at the local fishing factory, the Hout Bay Health Forum and home visits brokered by key community figures. Although the women attending the Family Planning and Baby clinic formed the core of my research, I also interviewed young mothers in their homes, schoolchildren sitting outside the hospital, ex-gangsters receiving TB treatment or attending the disabled group. I frequently moved to the area outside the hospital, 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.

The majority of the patients interviewed were from the Hout Bay harbour area, though a few were from the nearby Imizamo Yethu squatter camp. My interviews were conducted in English or Afrikaans depending on which language the informant preferred. Informants often switched between English and Afrikaans, the local vernacular, interspersed with 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.

Some of the interviews were conducted through a Xhosa translator, a nursing assistant in the clinic. This often proved problematic as I sensed she was changing some of the contents and meanings to what she thought I would want to hear. She also often reprimanded patients for not complying with their treatment regimens.

Participant observation at times proved useful. 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.

Frequently the only “free time” that medical staff had was during 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 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. 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 have changed the names of informants and staff. This is to protect and maintain patient and staff confidentiality.

1.14 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 and reproductive health care 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.

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 various 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 extend the '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 and family planning.

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 offer some suggestions for future debate and research and the possible value of this research for current health care initiatives.

2. 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?

The fact that there is very little interaction with texts in the sense that there is minimal 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 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.¹⁰

2.2 Description of Space

2.2.1 Entering the institution

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. 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, Apostolic and Catholic church. 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.

Nurse: 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. 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 area 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.

The minibus taxi rank is situated further down the hill. There are people milling about and a few taxis are parked at the taxi rank. Schoolchildren 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 with babies, and older people walking up and down the hill. The neighbourhood assumes a rhythm of its own. Some men are sitting on the pavements talking and some are standing in the street or in the small parking lot and driveway of the hospital talking 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 of the nearby fishing factories,(depending on the wind) the hooting of cars and minibus 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.

The Day Hospital, where all services and supplies are provided free of charge, is easily accessible to most people living in the community. It is a social nexus for many people residing within the community. Patients frequently refer to the day hospital as part of their "family and home". Likewise, within the community, similar sentiments are voiced. Thus it would appear as if the Day Hospital has been incorporated as part of their social world. The assumed division between a medical institution and the outside world or community has become blurred. I am not however suggesting a pristine community untouched by outside influences. Apart from the youth, most residents rarely venture forth outside of the community. People go to a nearby suburb Wynberg to "Coloured Affairs" to collect their pension or disability grants or to outlying hospitals for maternity and other medical care.

In drawing up rudimentary kinship systems, I have often been able to record at least four generations of kin still residing in the Hout Bay area, this further reinforces the notion that family structures are stable in that there is little movement in and out of the area.

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. The manoeuvring of cars in and out of the small parking area which doubles up as a back yard and general meeting area is 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. A security guard sits on a chair in the front parking lot and occasionally propels himself around in one of the wheelchairs. I find this rather odd and am surprised that no-one has reprimanded him for this action. This further conforms to the notion of how people have informalised the hospital space.

One enters the hospital 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 hospital. The entrance and exit assume symbolic meaning because in numerous ways they embody the dynamics of the social practices present in the day hospital.

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 hospital and in their refashioning of the practice of queues and appointments.

The procedure at the reception desk which requires patients to register and fill in forms, 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 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 hospital. 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.

This procedure has been recently modified. Patients are now given their own medical folders and sit on the benches outside the doctor's office with their files.

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: I am here waiting for my girlfriend. I will meet my girlfriend here, she has to collect her pump for her asthma.

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

Brandon: No, I am at school.

Ethnographer: Aren't you supposed to be at school?

Brandon: 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 : "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. I ask him what he plans to do now. He replies: "don't worry, 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.

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 Southern Peninsula Municipality which runs a Primary Health Care Clinic consisting of the Family Planning Clinic and the Mother and Baby Clinic. Other services include a monthly Psychiatric Clinic, weekly Dermatology and Dental Clinic and twice monthly Termination of Pregnancy clinic and counseling. Patients

are then referred to a state hospital where abortions are performed. There are no visiting or district nursing services.

2.3.1 The Waiting Room and Reception

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 filing cabinets containing the patients' folders and files. In contrast to the outside waiting room there is a sense of order and an air of importance.

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. To the left and in the corner is a small window which opens into the dispensary where there are two wooden benches for people to sit on while they wait for their medications.

All medications are dispensed by a nursing Sister. There is a general sense of order and efficiency.

2.3.2 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.

2.3.3 The Family Planning Clinic

My observations and interviews in the Family Planning and Mother and Child clinic took place in the space outside the nurse's 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 box containing the patients' files and another into which patients place their family planning appointment cards.

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. I have not only focused on the family planning clinic as many of the women move between these other domains of the clinic often for related medical problems.

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 Waiting Room and Reception

In mapping who does what reading and writing in this domain and in the day hospital 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.¹¹ 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, and a disease typology.

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. 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:

- Please bring your appointment card when you attend this hospital. It is important to take care of the card. Keep in a plastic packet in a safe place or in your ID book. If you lose your card write your name and folder number on a piece of paper and place in box. A fine of 50c will be requested from patients who lose their cards. Thank you. Sister in charge.
- Attention please : Please sit in the waiting room until your name is called by the staff
- 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.
- Please use the bins.

In spite of the prescriptive tone of these notices, patients have negotiated a situation whereby the rules and regulations are not strictly enforced. I observe that the rules are frequently waived as many of the older patients who have forgotten or misplaced their appointment cards and who are known to the receptionist are seen by the doctor.

Thus, many of the older patients who are unable to remember their folder number are still able to by-pass the need for formal schooled literacy.

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 Pam”. She is not a nursing Sister, but is called Sister, due to her religious affiliations and hierarchical positioning in the hospital. 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. 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. Pam, as literacy mediator, has a particularly authoritative voice. She decides 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 infant was ill. She appealed to Sr. Pam 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. Pam performs the task of what Schifffrin (1994) has referred to as the “writing for the other”. Schifffrin¹² 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. Pam, but is linked to the process of induction into the medical institution and 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 hand-written 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 Pam 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. Pam: “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. 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.

Thus bureaucratic transactions are at times personal and most patients are well acquainted with Sr. Pam who has strong community ties. Her house is situated in close proximity to the hospital. According to the Sister in charge, Sr. Pam 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 hospital. 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,¹³ 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. I notice that one woman keeps her clinic cards in her brassiere and another patient keeps it in a suitcase under her bed filled with other 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. This system of keeping the patient's files separate has recently changed. I note that patients now sit outside the doctor's consulting rooms with their medical folders in their hands. Some of them are flipping through their files and reading. I ask the nurse in charge what is happening as this is the first time that I have seen patients having access to their own medical files. She states that they should be familiar with their own medical history and many of the patients feel a sense of self importance. Furthermore this change has facilitated the waiting process and helps the medical staff get through the heavy patient load.

However, many of the elderly patients are not able to read and if they are a lot of what is written is in medicalised code and abbreviations that is very much part of medicalized discourse and in a language, English, which they are not necessarily fluent in.

2.4.2 Family Planning and Baby Clinic

Pamphlets and posters 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, and pamphlets on various STIs such as herpes, gonorrhea and syphilis. Outside the family planning clinic is a timetable with the days and times of the family planning and child health clinics and a poster with emergency telephone numbers such as Lifeline, Rape crisis, Nicro support center, Safeline and Childline. These emergency telephone numbers are a reflection of the increasing domestic violence occurring in the community .

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 two or three months for their contraceptive injection. This is an important event, as it safeguards their reproductive status.¹⁴

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 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 or Nur Isterate. 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. It’s better to be safe.

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.

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 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.

Recently the situation has changed somewhat as primary health care initiatives becomes more entrenched. Throughout my fieldwork I was to notice a regular change of posters corresponding to government and health department initiatives such as World AIDS Day, World No Tobacco Day and Pregnancy Education week, plus various mission statements of the restructured health department using Alma Ata guidelines. These visual displays are manifestations of spaces of visual and material representation providing the capacity for creating and claiming this space as official hospital space signifying their sense of power.

2.4.3 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:

I know this bottle is for the "*hoes*"¹⁵ 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 elderly sisters from Kronendal farm, both had never been to school.

My sister is here to see the doctor for her “nerves”. Ethnographer: Do you have an appointment to see the psychiatrist? Yes, the letter is with the doctor. Ethnographer: What does it say? 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.”¹⁶ 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.

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 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.

Alongside the opening to the dispensary is a host of handwritten instructions pertaining to the overuse of medications and as of March 1999 cough medicines will no longer be available.

Outside the dispensary and doctor’s consulting room is a large notice board dedicated to AIDS related issues with a sign indicating the current number of AIDS patients. This number is changed on a monthly basis. The abundance and almost exclusive preponderance of AIDS related and safe sex posters is linked to the emerging health care crisis around AIDS / HIV and STIs. The spread of AIDS and STIs has been identified as the most pressing issue in the day hospital.

Currently the most overriding concern to staff in the day hospital is the increasing incidence of HIV\AIDS in the community, mainly localized to the nearby Imizamo Yethu informal settlement. On returning to the Day hospital in 1997, I was frequently alerted to the HIV \AIDS crisis and how it was “getting totally out of hand”.² So much so, that I was asked to help and provide counseling to newly diagnosed HIV patients as the nurses did not have sufficient time to fully explain to patients the implications of their disease process, nor did they have time to provide adequate counseling.

Health care workers and other community and health care professionals in the Hout Bay area have identified HIV\ AIDS as an important health care crises. An AIDS sub-committee was formed in February, 1997 as part of the Hout Bay Health Forum in direct response to this epidemic. The initial meeting of health officials and community leaders was convened by the head nurse of the Day Hospital. Their immediate goals were to provide long term AIDs education, involving health facilities, community workers, service organizations, churches, schools, youth groups, factories, and life skills programmes at the schools, to provide free

distribution of condoms, and the early detection and treatment of HIV. In addition, the need for Xhosa- speaking staff at the various health facilities was identified.

Committee members are diverse and include the local high school principal, social workers, doctors, nurses and health care workers from both Hout Bay clinics, traditional healers (Sangomas), pharmacists and other related medical personnel and ministers from the various churches.

A small black book, labeled the HIV Book, is kept in a locked drawer in the dispensary. HIV statistics have been recorded by the nursing staff on a monthly basis since 1995. The most common symptoms that HIV positive patients have presented with are other STIs such as gonorrhea and syphilis, and diarrhea and skin lesions. Gender distribution of the disease is fairly equal. For example, out of a total of 17 for November, 1997, 7 were women and 10 were men, the age distribution for women was 20-28 and 21-38 for men. Racial breakdown reveals two Coloured men and two Coloured women from the harbour community, the remainder are African men and women from Imizamo Yethu informal settlement.

2.4.4 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 Conclusion

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, or appointment cards, 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.

3. “THIS IS MY FAMILY, IT IS LIKE MY HOME” AN EXAMINATION OF LITERACY AND REPRODUCTIVE PRACTICES WITHIN SOCIALLY CONSTRUCTED SPACE

3.1 Introduction

The title of this chapter comes from 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.

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. We all know from each other. I love this place. 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.

This woman'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 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 and working 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. Many of the women that I was to meet were family members were somehow connected to the fishing industry. Many of the women work in the fishing factories on a seasonal or casual basis. An informant, a woman who is a supervisor at one of the fishing factories that I visited recounts how she merely contacts these women depending on the amount of fish available to be processed in the factory. This varies from day to day, depending on the amount of fish brought in. She knows most of the young women in the community and who is available to work at short notice, and clearly has her own network of locating casual employees.

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 practices. 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, is a residential 'Coloured area', situated within the greater Hout Bay area. The total population recorded in 1998 was five to six thousand. With the Valley's (the white section) population estimated at ten thousand and Imizamo Yethu informal settlement estimated at ten to twelve thousand though the latter is difficult to estimate as the population is transient and many are illegal immigrants from Namibia and Angola.¹⁷ 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. 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

The area is filled with contrasts and structural remnants of the apartheid regime and Group Areas Act of 1950.¹⁸ Coloured people who resided in the now White areas of 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 or socio-economic position are detected in the conversations and narratives of staff, patients and residents. There is the White residential area of large houses and the “village” consisting of guest houses, shops, estate agents 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 locally referred to as Dallas and Texas, the gray fishermen’s cottages occupied by fishermen and their families situated in close proximity to the harbour, and the men’s hostel or compound built by the fishing factories in the 1950’s now occupied by fishermen and workers from the Transkei, Namibia, Angola and Kwa Zulu-Natal. According to informants and social workers in the community the more enterprising rent out their rooms in the hostel to others for a fee, and live in nearby Imizamo Yethu informal settlement.

Further alongside the mountain are the red row houses or flats called “Snake park”

People tend to build Wendy houses or bungalows in their backyards or on open land behind their houses where they house younger family members or relations and are able to “illegally” feed off electricity and other utilities from the main house.

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 area and up the hill to Hout Bay Heights and are luxurious in contrast to those at the bottom of the hill. These are large double -storied houses replete with burglar bars and alarms. According to a prior resident of the harbour community and who now resides in Hout Bay Heights, only five families originally from the harbour area now live in Hout Bay Heights. I am informed that “wealthy Muslims” live in Hout Bay Heights as well. The area is racially mixed. With the demise of the Group Areas Act in 1992 a few white families have bought property here as property remains less expensive than in the predominantly white section of Hout Bay. A well appointed guesthouse has also recently opened in Hout Bay Heights.

The topography and landscape of the area, bounded by the Atlantic ocean, the Karbonkel mountains and Chapman’s Peak Drive constructs and reinforces further geographical isolation and impacts on the political-economy of 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 Mother and Child clinics were unemployed or worked on a casual, or seasonal basis

at the fishing factories or in shops in the nearby shopping centre though usually on a part-time basis as well.

There is one high school in the area, Sentinel High School and a primary school as well. There is a public library and situated alongside the library is the civic center which has a hall which is rented out for various occasions such as 21st birthday parties and weddings, next to the civic center is a crèche and a nursery school. A large sports complex adjacent to the day hospital is currently under construction. There are also a few grocery shops, the Diamond Liquor store and a doctor's office, a general practitioner in private practice. There are numerous churches in the community, an Anglican church, Catholic church, Apostolic church and a mosque. This small area has a well established infrastructure and the village of Hout Bay is close by with all the other amenities.

Spatial and racial segregation are predominant features in this community. Not only have they been constituted out of apartheid's segregationist policies but are perpetuated within the community. Apart from in the hostels no Africans live within the harbour community. There appears to be very little mixing, even in the hospital people tend to sit separately.

The relative insularity of the community is epitomized by a nurse who attributes the high incidence of epilepsy and psychiatric problems to intermarriage within the community. In this instance the nurse is pathologizing the community with an ad hoc epidemiology and hence attributing various social and medical problems to intermarriage and kinship. Residents frequently refer to incidents of intermarriage within the community but within a different context. Intermarriage occurs as people tend not to travel outside the immediate environs of Hout Bay. A resident comments: "they, that is outsiders, say *ons bly onder die klippe*", which he translated as "living behind the mountains"¹⁹ and rarely venture forth from behind these mountains.

3.3 Spatial analysis

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, mother and baby clinic and the doctor's consulting room.

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, 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 parking lot, 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 .

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,²⁰ 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. I have met this young boy on numerous occasions and more recently while interviewing a woman in the family planning clinic noticed him in the waiting room. This woman knew him and informed me that he had missed school the previous day as well.

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. Lance, 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. 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. 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.

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". I ask the staff about Lance. They inform 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 or nurse, 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 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.

“Inside\outside”, “them and us”, *inkomers* 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. This is evident in the changing and contradictory discursive positions adopted by patients and staff.

The following spatial stories are closely linked to notions of identity around the place itself. Issues of language also come into play. Different registers and modes of communication are employed. Many of the young women in the family planning clinic speak Afrikaans amongst themselves but when speaking to me or using medicalised discourse frequently code switch to English especially when using medical terms such as the injection, normal delivery, undiagnosed twins, ultrasound and breech delivery. In their homes they frequently tend to speak to me in English.

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, somewhat insular 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.²¹ 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,²² 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 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.²³

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" or as "hand outs".

Two local women who I meet in the community refer to the same kind of problems though articulated in a slightly different way. They both refer to apathy, lack of commitment and expecting everything for free or as hand outs.

I visit the Disabled group on numerous occasions. I am struck by the group leader's motivational talk at their first meeting after the Christmas holidays. She announces her plans for the forthcoming year and how things should be improved on. A central concern is reliability, commitment and that people should attend on a regular basis.

All the people attending the disabled group are receiving state disability grants. Their disabilities vary, some have chronic medical conditions such as epilepsy whereas others have physical or mental disabilities ranging from spinal chord injuries to schizophrenia.

The group leader addresses the group stating that:

You need to learn a skill, something that you can do to start your own business. We must be able to sell the goods that we make. You must learn to be self sufficient, learn a skill so that you can start your own business. You must be able to say "Wat het ek gegain van die group"(what did I gain from the group here she is mixing English and Afrikaans.)You must attend regularly, I want some kind of commitment to yourselves and the group.

Likewise, Vanessa, an articulate thirty six year old woman expresses similar sentiments. She appears to be a self appointed “watch dog” and cultural critic of the community. She is a sales manager at a department store in one of the nearby suburbs and informs me that she has attended a self sufficiency course and was previously a shop steward.

You see, Miss, these people are lazy, apathetic and just not interested, they couldn’t be bothered. The women might do some part-time work, clean their houses and then just sit outside or walk to each others houses, but they do nothing else, they show no interest in what their children are doing. I see at school meetings they do not attend or show an interest in homework or extra curricular activities. Whereas, I keep my children very busy with outside school activities and when I am at work I know where they are and what they are doing. These people expect me to do everything for them. They must learn to help themselves. They always want everything for free, we must learn to do things for ourselves and we must know our rights.

She further describes an incident that occurred recently in which a six year old girl was raped by a “wealthy Coloured man” from the community. Many informants have related this incident to me in one form or another. She recounts how on “that Sunday all the newspapers were sold out. There was not a single newspaper to be had. This is the only time that the people showed any interest in what was happening in the community, and I tell you everyone from this community will be at the court for his hearing”.

Yet ironically when I met Vanessa she had already seen the doctor for a minor ailment. She had taken off from work, traveled a distance to the day hospital, and was now long after her doctor’s appointment still standing outside in the sun chatting to patients and people who entered the day hospital. I asked her if she wasn’t concerned about getting back to work as I didn’t want to take up her time with our conversation but she informed me that she was in no hurry to get back to work and that she could stay and talk to me.

The moralizing discourse in these narratives suggest that certain behaviour patterns are entrenched within this community. However these narratives are often contradictory further indicating the varied positions that people assume depending on social context. Vanessa criticizes the lack of self- sufficiency and social responsibility in the community and how people take things for granted yet she too in a sense has taken advantage of her work situation and is quite happy to spend time away from work.

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. 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. 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 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.

I might not always know their names but I know their faces.

Women attending the family planning clinic have echoed similar sentiments.

A multi-generational perspective was elicited through visits to the Senior's Club. The following comments were voiced by a group of elderly residents at the Hout Bay Harbour Senior's Club.

Here in Hout Bay people are taking notice from each other. I don't think there can be another place like Hout Bay. We know one another, love and understand each other. We were taught by our elders to always look out for each other. Here even the young people and gangsters still respect their elders. Yes, even these gangsters don't interfere with us they still have respect for us.

The narrator's comments can be read in many ways. In this instance as a form of neighbourliness and support, in contrast, according to young unmarried mothers, it is also about being a busybody, knowing everyone else's business, gossiping and spreading rumours about others.

People are constructed by many of the elderly women as *inkomers* (outsiders). One can still be considered an *inkomer* even after having lived in the community for fifty years. This further reinforces the notion of a closed, bounded community with a certain collective identity.

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).

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

I draw on Bakhtin'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. Amidst the raucous laughter and general fanfare is the authoritative voice of the nurse calling patients to order.

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.

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.²⁴

I am telling you, this place is full of bullshit. They really give very little medicine. Excuse me Madam, but it is unfair, it's a whole lot of nonsense.

I meet a woman attending the family planning clinic who complains that immediately after giving birth to her baby she was given the contraceptive injection Depo-Provera.

Miss, that is not right. I mean, I was in so much pain after the birth of the baby that I had no time to think or even feel that injection. But I suppose I am safe now. But I rather want to go on the other injection, the two monthly.

The latter complaint might not be as vivid as the previous narrator's. In a more discreet manner, she voices her dissatisfaction and is able to challenge, in an

indirect way the authoritarian attitude of the nursing staff. Through these different speech genres; laughter, silence, profanities and the appropriation of unofficial discourse, patients are able to express or say something.

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: "I am going out tonight, that is why I am wearing my curlers".

Shilling (1993), has argued that the body in high or late modernity 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.

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. One of the schoolgirl's 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.*"²⁵ 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, self confessed gangsters receiving TB treatment hanging about in their pajamas are all violations of the rules and norms of formal institutional space.

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 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.²⁶

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).

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. 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. I feel satisfied with myself. The other patients are sickly and talk in a mixed up way. 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 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.²⁷ 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. 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 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." Similar comments are made by the nursing staff in the family planning clinic with regards to the use of contraceptive technologies. I enquire about the high use of injectable contraceptives and the low oral contraceptive use. I am frequently told that it is due to "lifestyle issues and norms" and that "forgetfulness" i.e. to take a pill everyday, is linked to social and lifestyle conditions.

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.²⁸ 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.

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.²⁹

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.³⁰ I even received notices from the Social Welfare Department stating that the baby wasn't picking up. I was concerned that if 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."

Ethnographer: "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."

Ethnographer: "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.”

Ethnographer: “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 headhunters 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 formal³¹ and local registers³² 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.³³ 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 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 de-stratify. 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 Conclusion

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 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 rules³⁴ 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.

4. BODY LITERACY AND FAMILY PLANNING

4.1 Introduction

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 literacy enabled me to uncover hidden literacy practices, (those not strictly alphabetic) and to thereby understand dissonances and disjunctures that had previously appeared incomprehensible.

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 its system of observation and record-keeping circuits. 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 and diagnosis 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 practices of institutional reading; recording, encoding and decoding technologies and practices that make up medical literacy.

Foucault's concepts of the disciplined and morally regulated body and "technologies of inscription" provides a framework and an initial point of reference to uncover the textual dynamics at play in hospital and clinic settings. In this study I move away from using strictly print literacy defined as alphabetic literacy and numeracy, to alternate forms of inscription. The frameworks of technology and inscription are useful, for this allows one to expand definitions of literacy as technical practices centered on print materials, to other forms and sites of inscription and decipherment engaging the human body.

In order to address the diverse literacy practices of medical practitioners and patients within the medical milieu, the concept of literacy can be extended to include practices or techniques of inscription on the human body. Thus literacy as situated social practice (Street 1993) can be expanded to body or somatic literacy as one further arena of encoding and decoding. The body and its parts consequently is decipherable, and viewed as a writing surface, upon which social messages, meanings, and values are inscribed. This notion that the human body is a terrain to be "read" and "written" in diverse ways is theoretically supported by the works of Foucault (1979) and Kapitzke (1995).³⁵ However, reading the body is a practice that is not limited to experts, persons in states of illness and dis-ease also engage in interpreting and translating their own bodies.

This chapter examines culturally mediated literacy practices in relation to medical texts and contraceptive choices amongst patients attending the Day Hospital. The central ethnographic focus of this chapter will be on the women attending the family planning clinic, which forms an integral part of the day hospital. I argue that these women do not only utilize their reading and writing skills, but draw more on other cultural tools that enable their reappropriation of the medicalized body in order to address extra-medical issues posed by cultural norms from their social context. They deploy certain medical technologies and practices, more specifically the contraceptive injection Depo-Provera, to negotiate sexual relationships, reproductive issues and relations of gender power in sites beyond the clinic. Following Mauss'(1973) concept of techniques of the body, I suggest that the women have positioned their own bodies in order to make necessary choices in accordance with their local social context and gender relations.

Although most patients attending the family planning clinic were able to read and write, I sensed a disjuncture and dissonance in the manner in which they related to medical texts and in situations where the textual practices of the medical institution were most directly enacted and experienced. These dissonances were evidenced in the fact that on the one hand patients were alphabetically and numerically literate, yet they were not engaging with the texts in the form of posters displayed on the walls, pamphlets, and instructions on medicines and clinic cards. What I was yet to uncover was the women, were more concerned with their own vernacular interpretation of medical practices than with the signage and writing practices of the hospital which they did not always relate to as being addressed to them.

4.2 The Mother and Child Clinic

Post natal clinic care is an additional process (having experienced ante natal care and child birth) whereby many women in the community experience the medicalization of their bodies, usually through the surrogate of the medicalization of their babies. These examinations thus constitute an institutional induction or initiation process into the Mother and Child clinic. During my fieldwork I attended the Baby clinic where I sat as an observer inside the nurse's consulting room. The babies were receiving their state regulated vaccinations which included polio drops, diphtheria, tetanus and measles immunizations and more recently to babies born after 1994 Hepatitis B immunizations. I observed that there was minimal interaction between the mother and the baby. The mothers appeared indifferent to the activities within the consulting room and to their babies during these procedures. Few of the mothers visibly reacted to the sounds and cries of pain whilst the babies were receiving their injections. The nurses continued to examine and immunize, while the mothers passively sat.

The examination procedure included recording and measuring weights, lengths temperatures, and listening to their lungs sounds. The immunization schedule was written on the baby's clinic card and the mothers were informed via these notations when to return for the next vaccination. 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 a second record -keeper through compliance with the immunization schedule. The mothers are thus able to selectively relinquish responsibilities of child -caring and transfer these to medical experts.

However, the mother's posture in the baby clinic 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. There was minimal interaction between the mothers and nursing staff concerning reading, recording and quantification. Yet, a subsequent conversation with one of the mothers, indicated that she was able to decode medical literacies and distinguish between different types of medications.

I am always needing those medicines as my children are often sick with colds and chest troubles. My one baby was born like this, always with a non-stop cough. We always need

those antibiotics and cough medicines. She is also teething, I have used teejel and those powders but nothing seems to help.

This mother was able to differentiate between body signs and symptoms and identifies and correlates appropriate medicines, eg. an antibiotic for a recurrent chest infection, a cough suppressant for a perpetual cough and teejel for teething problems. The mothers were able to access the necessary knowledge in diverse ways but not through any active interrogation with the staff, nor through any reading of the various medical records that were deployed in, and generated by, the baby's examination. This mother was thus able, through her own local understanding, and not necessarily through reading able to decide what was of importance to her child's well-being.

This institutional space has power over the mother through the baby's medicalization. It appeared as if the mothers had given over the baby to autonomous institutional process. Further the baby's body became a space of mediation between the mother and the nurse and the primary means by which the mother becomes visible in the clinic as an object of the medical gaze. The presentation of the baby to the medical gaze is accompanied by the backgrounding of the mother's body which is physically present as an adjunct of the baby's body but which remains semiotically unmarked.

The presentation of the mother's self in the medical space both to local women and to the nursing staff occurs through the performative display of the baby, either as symbolic capital, a desired object that establishes the woman's social status as a mother or as a medical object (the baby in reference to the nursing staff). In a variety of ways the mother uses the baby's body to mediate and establish her own position and participation in the clinic space as a communitarian space. This in part can explain the mother's relinquishing of the baby to the medical gaze and her own apparent passivity in the consulting room. The infant is foregrounded as the visual social vehicle by which the mother presents herself in the clinic and institutionalizes the self in both the communitarian and medical space of the clinic.

4. 3 Naming patterns

The visual display of the babies in the baby clinic further contributes to the notion of the baby as a display of status and distinction. The babies are well-dressed with hats on their heads and bottles or pacifiers in their mouths. They are tightly wrapped in lace or ribboned shawls and blankets. A mother declares: "having a baby is like owning a doll, something of your very own". The baby thus becomes an ornament, a doll to be dressed up in pretty clothes. The performative dimension of the baby's presentation and display is also revealed in the naming system currently applied to infants. I inquired as to the babies names and note that the naming patterns are expressive of popular American TV shows, reflected in names such as Chad-Lee Nathan, Tiffany, Jade, Celine, Camilla, Keanan, Keena, Chanté -Brittany, Devin - Sidney and Brooke (the latter a mother informs me is named after Brooke in the "The Bold and the Beautiful" American TV soap opera). I would also go so far as to argue that these names are often signs of modernity and are also evidenced in the

name brand clothing items that many of the younger mothers wear, such as Nike caps, T shirts embossed with designer names such as Calvin Klein, Levi jeans and the like.

The spelling of names and ensuring that they are spelt correctly is also important to many of the mothers and their families. A young unmarried mother of nineteen informs me that “initially we had spelt our son’s name wrongly. We had to go and change it, we must make it right. His name is Micael but then we had spelt it wrong so we changed it to Mickyle.” Another informant discusses a similar incident in this instance the nurse at the day hospital had informed her that she had spelt her daughter’s name Chloe incorrectly. It’s not how it sounds I had spelt it “Clue” - it was wrong so I must still change it. Another young woman shows me a framed name chart of her daughter’s name prominently displayed in her bedroom. This name chart provides the origins and meanings of the name Kyra.³⁶ She further provides her own etymology of her daughter’s name.

“I saw a book with all the different names and they also had these posters with the various names. (She found this book at a shopping center quite a distance from Hout Bay). Kyra is a Greek name it means the sun and the light of life. You see Kyra is also the female side of her father’s name- Cyril”.

The informant’s mother at a later stage also provides the meaning of her granddaughter’s name: “It means sun, because she is my sunshine”.

A further example of the significance attached to naming practices is evidenced in my lengthy conversations with Alma a young mother of 4 week old twin boys, Pierre- Jonathan and Alonza- Jay, abbreviated to PJ and AJ. She provides a history of how they acquired these specific names.

The twin’s father said if it is a boy you should call him Pierre -Johnathon, that is his name, and if it is a girl you should call her Pasadena, Pasadena Avalanche. So I said OK. When they came out it was two boys. I still called the one Pierre- Johnathon and thought about it. My sisters thought about names as well and they looked up some names and they said Alonza -Jay, so we just call them PJ and AJ for short.

Alonza is an unusual name (ethnographer) - Yes, it is a Spanish name. We saw it in a book and we liked the meaning of it. Now their father phoned and he said I think you must change the names again to Justin and Jason so my mother said no that is a dog’s name (laughing). My mother said no they have got names already we will just keep it like that . I mean AJ and PJ that is fine.

These systems of conferral denotes the particular importance that the infant assumes to both the mother, her family and wider kin structures. It is interesting to note that many of these mothers expand on their literacy competencies by using specialized books to assist them in their selection of names. It thus becomes an important “literacy event”.

Display and performance, in this instance, is about how the mothers represent themselves and their babies in social space. The importance placed on the baby’s

attire and the time needed to prepare for the purchasing of clothes is recounted in the narrative of a young mother. Furthermore, she sees the birth of her baby as an endowment or “God’s gift” to both herself and her family. Thus “God’s gift” by inference are indexes of moral and social status given to the mother by a source outside the social order but which must be displayed to the communal gaze, the peer group of other recent mothers, and the clinic staff to establish one’s status within the social order.

I went to the doctor and he said: “Lady you are six months pregnant”. I was so surprised to find out so late in my pregnancy . It’s hard to explain because I hadn’t bought any baby clothes. I only had three months to buy baby clothes and ended up buying only the basics. Nothing really nice. In the end I had to borrow some old clothes from my sister’s child. My parents were very happy about the pregnancy because it was their first grandchild. First grandchild on his side as well. In my case I didn’t expect to have a baby it was a surprise so I didn’t plan to get married because I didn’t expect to have a baby. In my case I didn’t expect to be pregnant it was God’s gift to me.

Conception like the use of oral contraceptives is attributed to sympathetic magic. Pregnancy or conception thus comes as a “surprise”, something unexpected and not planned. This will be discussed further in the next section.

4.4 Contraception and Family Planning : Gendered and Spatial polarities

Perhaps the most pervasive prenatal practice at the clinic is the delivery of the contraceptive injection. To conceptualize the meaning of this contraceptive technology 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 manner in which power is inscribed on the female body through the processes and mechanisms of self-regulation, supervision and social control is fragmented and diverse.³⁷

The contradictory situation, whereby the female body is on the one hand subordinated, monitored and regulated and on the other hand is in process and invested with human agency, is the bedrock upon which I base my argument and the manner in which I ‘read’ the body in the day hospital environment. Women adopt multiple and often differing positions within the family planning milieu. On the one hand, women relinquish their bodies to reproductive technologies, yet on another level, their bodies become sites for reproductive autonomy and struggle. The contraceptive injection, Depo-Provera as a medical icon is re-contextualized and re-transcribed by the women attending the clinic as having both symbolic and material possibilities. Firstly, Depo-Provera is imbued with almost mythological properties. Secondly, in real material terms, it affords a degree of personal autonomy over their bodies and in their daily lives, and thirdly, it also reflects the power of medical technology and discourse which is both racial and gendered in its origins.

4.5 Family Planning as Key Event

The area assigned to the Family Planning Clinic is situated in the corner of the waiting room near the side exit. The women position themselves either in the main waiting room or directly outside the nurse's consulting room. Procedures are clearly structured by means of rows, queues, cards and folders which not only simplifies matters for the nursing staff but gives clients 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 converse with friends. They inform me that they will not lose their place in the queue as friends will locate them should their name be called in their absence. A client places the green clinic cards in numerical order, the nurse thanks her for her help. A simple procedure is followed; the women are first weighed, their blood pressure is recorded followed by the contraceptive injection, Depo-Provera which is administered by deep intramuscular injection every three months.³⁸

The contraceptive methods currently available in most government clinics are: hormonal injectables; Depo- Provera given every three months, Nur -Isterate administered every two months, oral contraceptives mainly Nordette and Triphasil, IUDs which are rarely inserted due to the high incidence of STIs in SA, condoms and spermicides, and finally sterilization. Emergency contraception and abortion are also now currently available however the latter is still extremely problematic. Female condoms are not currently available at most government clinics. Despite the various "choices" Depo- Provera remains the most pervasive form of contraception administered in the Hout Bay family planning clinic.

There is little verbal communication between staff and clients. They are not informed of their blood pressure or weight nor do they ask. A common side effect of Depo-Provera is weight gain, yet none of the women seem to comment on this phenomenon, with the exception of one woman who states: "I don't worry if I gain weight. It's better to be safe". The passivity previously identified in the baby clinic is also identifiable here. However, dialogue outside the consulting room is noisy and animated, the women continue to chat loudly and laugh, especially when I inquire about their method of contraception. A few of the older women prompt the younger women. They state in unison: "*Depo iets* (Depo something") *jy weet mos dis die drie maande*"(you know it's the three monthly). The neighbourhood is present during this event and overwrites the official solemnity with local informality. Events at the Family Planning clinic are transformed into communal practice. Women with their toddlers and babies frequently accompany each other to the clinic where they are likely to meet friends, kin and acquaintances. The nursing staff recognize many of the clients 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.

The contraceptive injection as medical technology, has been incorporated into the local vernacular, *drie maande* (three monthly), *Depo iets* (Depo something), *die inspuiting* (the injection), and has taken on its own cultural meanings often with

extra-medical ramifications. There is a certain communicative genre centered around the injection and a socialization of medical technology into everyday speech and rhetoric.

After numerous informal interviews with the women sitting outside the nurse's consulting room general trends were noted. I locate my ideas in the narratives recounted in response to discussions concerning contraceptive choices, health, motherhood and the family. All women³⁹ (with the exception of one woman who was new to the area and who sat to one side) were receiving the contraceptive injection, Depo-Provera. The responses to why women had not chosen the contraceptive pill was fairly consistent in linking forgetfulness to conception and hence pregnancy.

We hate the pill. We forget and then we are pregnant.

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.

If I take the pill today then tomorrow I am pregnant.

I always forget the pills. No thank you, I do not want any more children.

Another woman stated: I am on the three monthly, Depo. I like the injection. I don't like pills. I am not scared of the injection because I don't want any more children, *maar ek wil ook nie dat hulle my laat toe maak nie.* (But I also do not want them to close me up, a reference to sterilization).

For these women, there is a causal relationship between pregnancy and the contraceptive pill, the polar opposite of its medical function. The women claimed that they were forgetful, which is the reason why they preferred the injection to the pill. The pill embodies forgetfulness and their lack of agency. In contrast to forgetfulness associated with the pill, the precision with which they observe their medical appointments for the injection is reflected in the fact that women return timeously for appointments, their adherence to the queue structure, exemplified by one woman's eagerness to facilitate the process by placing the clinic cards in numerical order, and finally, the overwhelming 'choice' of Depo-Provera as a form of contraception. This compliance to the temporality of the clinic was also discernible in the mother's observance of immunization schedules in the baby clinic. The compliance to injection schedules indicate that while temporal adherence to clinic schedules is a form of institutionalization, women may find a level of empowerment and agency in this process in so far as the clinic schedules remove them from the "forgetfulness" that metaphorises the female body as biological fate, somatic vulnerability and lack of agency.

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

injection, is constructed and symbolized by 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 controlling. But ultimately this male symbolic capital is appropriated by women and feminized, it becomes a force of gendered agency. Furthermore, the pill has been inserted into folk epistemology whereas the contraceptive injection is seen as representing or symbolizing modernity.

I only have to look at the pill and then I am pregnant. Once I see that injection coming then I ask no questions. 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. I'm used to injections I've been having it already so many times. My friend who was on the needle started growing all kinds of hair - but for me the needle is fine because *ek will nie my laat doen nie* - (i.e. to be done is the colloquial for sterilization.) So, no thank you, I do not like the pill. You see this baby here, that is what the story of the pill is about. I just can't remember to take the pill everyday. How must I remember? There are so many other jobs in the house that one must do, like taking the children to school, cleaning, shopping and cooking.

The notion of forgetfulness voiced by many of the women takes on multiple meanings and can be connected to the loss of female agency within the domestic space⁴⁰. Forgetfulness in the domestic space may be linked to the exhaustion and time demands of domestic labour typified as household duties (cooking and cleaning) and child care. Thus forgetfulness, as in forgetting to take the pill everyday, leads to pregnancy which in turn produces further body labour in the form of pregnancy, birthing and child-care. Dependence on the pill is thus linked to the risk of pregnancy, all these realities signify loss of control over one's body. The experience of such loss of control in the domestic space forges the assessment of both domestic and reproductive labour as the loss of personal agency.

In contrast, the technological allure of the injection combined with the clinic's own enforced schedule of appointments relieve women from the burden of remembering how and why they need to reclaim their bodies back from the social conditions of the domestic space and the loss of bodily control associated with domestic labour and human reproduction. Pregnancy, giving birth and child rearing(domestic labour) all serve to tie women to the domestic space and to subordination of male hierarchies.

The discontinuity and paradoxes that emerge around specific notions of the injection as against the pill or other forms of contraception, such as sterilization and condoms, reflects the multiple and contradictory ways in which medical and gender ideology works and reflects different hierarchies of power (husbands, male partners and public health discourse).

The key questions then were:

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

4.6 The Hidden Practice of the Injection

The women attending the family planning clinic saw a direct causal relationship between the pill and pregnancy. 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 causational logic by simply looking at, or being in spatial and visual proximity to the pill is perceived to occur through the metaphor of sympathetic magic. The rapidity with which conception occurs further amplifies loss of agency and control identified with the domestic space. The final proof of the pills’ unreliability is voiced by an informant: “you see this baby here, that is what the story of the pill is about”. This reference to the baby is tangible proof of the pill’s 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.

The pill’s stigmatizing visibility is conveyed in the following narrative recounted by a young mother. She further emphasizes loss of memory associated with taking the pill.

Often our husbands want us to have more children. I say no thank you, not me. You see, 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 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, but 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 home, visible and thus potentially subject to the male gaze. The injection is hidden from their husbands, it occurs in a clinic beyond local male control and beyond their gaze. In hiding the pill and hence concealing the action, resistance and defiance is directed towards male domination in the home.⁴¹

In this context of hiding, the clinic embodies feminized space, it is beyond the male gaze associated with the domestic sphere. The injection, like other medical practices, is a relative unseen and another power which organizes women’s bodies. It detaches them from male control in the domestic and community sphere. The female body thus becomes discontinuous between these two spaces of bodily control.

The valorization of the injection in the context of both medical treatment and cure and contraception is reflected 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 to one side. She informs me that she is attending the Family Planning Clinic, but has also come to get pills for her shoulder blade. I inquire as to what happened. She informs me that a wardrobe fell against her shoulder blade.

That must have been very painful. Did it fall over ? (ethnographer) I notice that she has a large bruise around her left eye. She replies: 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. I get the three monthly. 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 pynappel en uit soos n piesang.(In like a pineapple and out like a banana.)

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. Women claim that the injection "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.

The history of Depo-Provera contains a specifically racial component. Since the 1970's Depo-Provera has been used extensively in South Africa. In contrast to other health services such as immunization and high rates of infectious diseases, SA had an effective family planning programme and services directed towards the black population.

It is now widely accepted by most observers both within and outside government circles that the primary motivation for both the Family Planning Programme in SA and the Population Development Programme was the fear within the white community in the 1960's and 1970's of being swamped by the larger numbers of the black population. Depo-Provera thus became associated with population control and coercion and by the white government's attempts to control and limit African women's fertility. In 1974 the government introduced a national vertical Family Planning programme. A nationwide network of Family Planning clinics was established with free services provided to all racial groups but on a segregated basis. At the same time positive incentives were offered to the white population to increase the number of children per family (Sai,F, Rees,H & McGarry,S,1993: 7).

Stories of coercion abound Depo-Provera was reportedly given to women in labour wards immediately after giving birth, a practice that was allegedly so widespread that nurses in SA government hospitals for Africans had a saying that "Depo was the fourth stage of labour" (Sai, F, Rees,H & McGarry,S, 1993 :16). This practice continues today and has been reported by many informants living in the Hout Bay area.

A young unmarried woman describes this practice.

At the hospital they make you take the contraceptive injection so you won't forge Mine was a normal birth. They gave me the injection straight after the birth. I didn't even have time to think and the birth was so painful that I didn't even realize that they gave me the injection. So now I am on the three months.

In addition, the nurse in charge of the family planning clinic informs me that: "It is unethical to give Depo-Provera post partum, it's not right but the nurses are concerned that the women won't return for their six week check up and contraception" Nurses in these maternity hospitals have thus assumed the role of moral custodians and guardians of the state and further reinforce notions of forgetfulness as previously discussed.

Taking cognizance of the negative inferences surrounding Depo -Provera I would argue that the Depo-Provera controversy demonstrates the complexity and ambiguity of the relationship between the state and women especially when control over women's reproduction is of central concern. However as indicated by my findings this whole debate needs to be localized where the issues might be somewhat different.

4.7 Paulina and Martha: Two Embodied Biographies.

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

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.

At a later stage Paulina recounts how she had sustained an abdominal burn from a glass Coca- Cola bottle improvised as a hot water bottle to alleviate stomach cramps. I asked her if the pain and discomfort had not woken her during the night. She replied: "No, it is only when I saw how red my stomach was in the morning that I felt 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".

Following Douglas (1966), bodily boundaries or margins 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. Many symbols can stand in place of moral binaries, pure /impure; order/disorder; above

and below(Hertz,1960). Paulina's bodily transgressions had caused disorder on many levels, through the burn to her abdomen which was dealt with once she entered the medical space (representing order) and to her possible STI which could only be dealt with once she had made an appointment, a further order. Thus symbolic resolution is sought through bodily order, represented by medical technology and cure. Disorder in the domestic sphere is further symbolized in terms of her unemployment, four children to take care of, and a husband who has left her. Order is represented by the man with a "good job", but who has, through traversing her bodily boundaries, created further disorder.

It is only once she enters the medical space that she is able to disembody her pain and trauma, by relinquishing the affected part of her body to medical technology and treatment. She thus moves from 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. The hospital had become a place or space in which to seek narrative and somatic closure.

The clinic and domestic space polarity is illustrated in the narrative of Martha 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. Furthermore, it ensures order in her sexual \ reproductive life.

Martha a Xhosa-speaking woman resides in Imizamo Yethu squatter camp. She is chatting to two other women in the waiting room. She informs me that she is waiting to see the doctor. Our discussion is conducted in English. 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." (She 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". Martha 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". I asked her if she did not wake up to the paraffin being poured over her body. "No, only afterwards". I later discover that the wound had been inflicted two to three days prior to her initial hospital visit. I met Martha once again and she informed me that her burn had healed. "Now there is no more to tell, I am better again."

The aggression of pouring paraffin over her body occurs in the domestic sphere, the medical sphere treats the burn. While her wound 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) she is silent, as the medical gaze has sealed it and terminated the discourse of pain, reflected in "now there is no more to tell. I am better again". She also relates the violent incident through the witness of a third person (her employer) who notices her pain, suggesting a further distancing from her open body.⁴²

This is analogous to the injection /pill polarity, whereby the injection metaphorically seals the body through preventing pregnancy, in contrast, the pill through its 'inefficiency', opens the body causing pregnancy, though for many of 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).

In the case of Martha, the burn is tolerated and endured, it expresses 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 drink tea and 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. Moreover, women's discourse around the adverse experiences in the home environment is part of the unwritten or unspoken body, that which can not be definitively named.

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 nerves⁴³ and the 'salve and pain pills' that can heal the burn.

4.8 Sexual Practices

Issues around safe sex practices and the prevention of sexually transmitted diseases (STIs) and AIDS is frequently 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.

Numerous attempts have been made by the staff to address the rising incidence of AIDS and STIs so much so that over the past month most of the patients from Imizamo Yethu squatter camp have been redirected back to the clinic located on the border of Imizamo Yethu. A doctor visits this clinic once a week and deals specifically with STIs and AIDS.

There are numerous posters on the walls alluding to AIDS, STIs and hepatitis , however, I rarely notice people commenting on these posters and found that they often formed part of the walls of the institution.

The distribution of condoms is neither visible nor is it openly discussed. Condoms that are dispensed are placed in awkward places, either behind the reception desk or in the treatment room in a box labeled condoms and thus not easily accessible. Clients are thus obliged to ask the receptionist or nurse for condoms. Condoms are also placed in small brown paper bags to ensure privacy usually given out as part of the treatment regimen for STIs and HIV.

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 STIs. Various folk tales abound about the potential dangers of condom use as evidenced in the following narrative. This excerpt forms part of a wider narrative around childbirth and the unexpected delivery of twins, what this woman referred to as “undiagnosed twins”. What is interesting about this narrative is that this woman uses medicalized discourse and has a sophisticated understanding of medical issues and the entire birthing process. She knew about the dangers of placenta abruptio, the difficulties of delivering a breech baby vaginally and the fact that identical twins originate from the same placenta explained to me as: “They are identical twins because it is from one placenta, so they are supposed to be identical but I can tell the difference”. In spite of this she has her own local and cultural understandings of contraception and the hazards of using condoms i.e. that it might get “stuck” in her or disappear. In discussion about the various forms of contraception that she has considered I ask her how she feels about using condoms.

Ethnographer: What about using condoms? That might solve your problems. No, my boyfriend doesn't like using it and I don't like using it. Because I am too scared to use it. That you might fall pregnant?(ethnographer). No, not that I might fall pregnant, but that it might come off. I am scared about that and it's stuck in me and then I have to go to the doctor and have it taken out. That seems to be happening a lot and that is why I don't like condoms. That is the fear that I have got. Do you think others have that fear as well (ethnographer)? I don't know about other people but that is the fear that I have got. I think I read about it in a book or something about that - that it did come off. It came off in a lady and she had difficulties and she had to go off to the doctor and have it taken out so I said no I won't use that ever. Before I had my first child I read that and that is where I said to myself I am not going to use that and I am not going to use birth control.

Studies elsewhere have shown that the use of condoms, are associated with infidelity, immorality and promiscuity (Finger & Barnett,1994; Mbizvo&Bassett,1996).

A discussion with one of the nurse's further suggests the moral discourse around the use of condoms leads to a further hidden practice.

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.

4.9 Conclusion

The women interviewed have re-embodied their gendered experiences through medicalized vocabularies, technologies and spaces. Based on the symbolism of the open - closed body they have sought symbolic and pragmatic resolution for their gender related issues in medical procedures and metaphors. One medical technology, the contraceptive pill, exacerbates negative gender dynamics whilst another medical technology, the injection, is turned to for protection and empowerment. Women’s appropriation of Depo- Provera and their reading of this reproductive technology in contrast to the pill, is an alternative literacy. These women invert the function of the pill through sympathetic magic and fear of loss of agency and control, whereas Depo-Provera Provera, is associated with the restoration of female agency.

The contraceptive injection, in their view, affords a certain amount of freedom and self autonomy. By choosing the injection as a form of birth control these women have both introjected the medical gaze and re framed it in terms of their own everyday life worlds. They relinquish their bodies to medical technology, yet through these actions they are able to free themselves from forced reproduction. The rescripting of medical discourse thus occurs at the level of resistance, negotiation and mediation. In all these instances “the body imbued with social meaning, becomes not only a signifier of belonging and order but also an active forum for the expression of dissent and loss thus ascribing it individual agency” (Lock 1993:141). But this notion of individual agency is rendered problematic once one considers the wider political and historical context of Depo-Provera as a form of birth control.

Despite the cultural patterns discussed one cannot disregard the controversy and negative inferences surrounding Depo-Provera and its place in feminist discourse and medical debate. As previously discussed the use of Depo-Provera as a contraceptive method advocated, distributed and popularized in developing countries has associations of curtailing the rights of women over their own reproductive processes and has been used within the framework of coercive family planning programmes (Knowles & Mercer 1992; Sciortino & Hardon 1994; Morsy 1995; Olu Pearce 1995; Rees, Sai & McGarry 1993; Kaler 1997).

Depo-Provera has been popularized not only by state and public health discourse but by the Hout Bay women themselves. The prior objectives of state family planning policies in South Africa emphasized demographic imperatives in curtailing the birth rate. The conceptual framework of state health policy has undergone major changes in the post apartheid years with current policy encompassing a broader vision of reproductive health care. Yet, the majority of women still prefer the use of

injectable contraceptives (Shapiro 1996). One important reason for this preference is its preventative efficacy, especially in the context of many women's social and economic realities. However, my data suggests that the contraceptive injection may be preferred in many communities because it is a "hidden practice" which takes place away from the male gaze in the domestic sphere as against "the pill" a regimen which is visible on a daily basis.

A central contradiction emerges around women's desire to have a baby and conversely the need to avoid pregnancy. I have discussed the performative display of the baby in the clinic setting. Yet these women also seek control and autonomy over their own reproductive processes though their use of contraceptive technologies. In this setting childbirth can be viewed as a rite of passage which loses its valence once one has one's first baby. Pregnancy thus involves a shift in embodiment from the body as vulnerable to the body accorded social status with the display of the "voorkind" translated as the before child, or first child. My research suggests a pattern of having one's first baby at a relatively young age (15 to 19 years), followed by a 4-5 year interval.⁴⁴ Perhaps the need for avoiding a second pregnancy is best explained in the choice of the contraceptive injection as a form of fertility regulation as against the "pill" which is considered less effective in preventing pregnancy.

In this chapter I have used an anthropology of the body to access multiple literacies by exploring the manner in which contraceptive technologies are given differing readings and interpretations. This has implications for the literature on reproductive health which frequently does not look at the body in its wider socio- cultural context. Furthermore, an anthropology of the body perspective demonstrated how medical subjects re appropriate dominant medical literacies and transform the latter through the mediations of local social context. By looking at various bodily representations such as experiences of pain, wounding, the open and closed body, and the social symbolism of pregnancy and childbirth I was able to access issues of female agency and how it can reveal local re-appropriations of medical technologies and reproductive health discourse.

5. CONCLUSION

5.1 Conclusion

In this concluding chapter I provide a framework within which to 'read' my conclusions. I confirm the arguments suggested in the previous chapters and I offer some suggestions for future debate and research commenting on the value of this research for current reproductive 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 both in the field of literacy and adult education, and within the field of women’s reproductive health.

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.

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 of my original research plans. 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 reproductive technologies played a crucial role), were most directly enacted.

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.

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 women 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, contraceptive names on clinic cards, 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 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 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. 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.

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.

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.

Giddens'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.

In the light of the foregoing research project I would 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.

5.2 Implications for Reproductive Health Care Initiatives

Despite references in academic and public discourse to different kinds of literacies - computer literacy, functional literacy, visual 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'. 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 resonance's 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 vernacular speech.

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 and community members' frequent references to the need to educate and teach people, the intended pedagogical material did not appear to have any direct impact and I rarely witnessed patients engaging with these texts or other initiatives.

The AIDs epidemic in South Africa is receiving constant national attention.

According to South African Health Minister Dr. Zuma, approximately 3.4 million - one in every eight adults-are infected with HIV. It is estimated that there are 1,500 new infections daily. HIV prevalence has increased 33 percent since the end of 1997, when there were about 2.7 million people with the disease in South Africa. (Washington Post 03/04/99).

Numerous attempts have been made to address this serious problem at both the local and national level. At the national level education initiatives have been the main focus and similarly at the local level. However, policy makers still tend to overlook the very people that they are intending to address. I propose that it is crucial to explore where the local intersects or diverges with the national.

Unless these issues are highlighted and taken into consideration in terms of peoples' 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.

Furthermore, one needs to take cognizance of women's own reproductive health care strategies and see where they intersect or diverge with the overarching frameworks and initiatives of reproductive health care policy and implementation.

As Zewdie (1993) has cogently argued women should participate equally in personal and community strategies in attempts to prevent the transmission of STDs and AIDS and in their own reproductive health care practices.

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