

‘THE GRANT IS WHAT I EAT’: THE POLITICS OF SOCIAL SECURITY AND DISABILITY IN THE POST-APARTHEID SOUTH AFRICAN STATE

HAYLEY MACGREGOR

Social Anthropology, School of Social Sciences and Law, Brunel University, UK

Summary. In South Africa, disability grant allocation has been under review and tensions are evident in government rhetoric stressing welfare provision on the one hand, and encouraging ‘rationalization’ on the other. This ambiguity is traced down to the level of grant negotiations between doctors and ‘clients’ in a psychiatry clinic in Khayelitsha. Here ‘having nerves’ embodies the distress associated with harsh circumstances and is deemed by supplicants as sufficient to secure a grant. The paper illustrates how national discourses influence the presentation and experience of suffering and the way in which doctors mediate diagnoses. The implications of local understandings of ‘health citizenship’ for expectations of the post-apartheid state are explored.

Introduction

This paper examines the political dimensions of social security provisioning by the post-apartheid South African state and the manner in which national political discourses become refracted through the prism of local illness experience. Ethnographic description of the expectations associated with the negotiation of disability grant allocation in a local setting, namely the Khayelitsha psychiatry clinic, is provided to demonstrate this. Particularly, the paper focuses on the ways in which changes in grant criteria influence people’s experience of illness: specifically the way in which mental distress is conceptualized and presented in different contexts. The differences that are evident in the local politics of grant allocation, as demonstrated in the clinic, parallel ambiguities evident in state social security policy. The material thus illustrates the contested nature of the category of ‘disability’ in South Africa. Whilst questions of eligibility have come to the fore, most explicitly in debates about the appropriate allocation of grants for HIV – a topic beyond the scope of this paper – they are much more pervasive than this. The final part of the paper interrogates the ethnographic data in the context of the centrality of the rights discourse in the post-apartheid nation-building endeavour, and considers what such an analysis can contribute to ways

of understanding the relationship between local and national ideas about human rights and their implementation. What does this ethnographic material reveal about local notions of 'public health' and human well-being? What has been the influence of the prominent discourse of human rights on the connections posited between health and citizenship in a place like Khayelitsha? Finally, what might local ideas about entitlement to social security reveal about expectations of the post-apartheid state?

The ethnographic material is drawn from fourteen months of fieldwork conducted in 1999 and 2000 in Khayelitsha, Cape Town. Khayelitsha is a large formerly 'African' township, situated on the outskirts of Cape Town. It is notorious for violent crime and an estimated 33% of the population is thought to be permanently unemployed. Poverty and illness exist hand in hand and a study determined the infant mortality rate to be 38.3 per 1000 live births (Mash, 1996). I am medically trained, which aided access and influenced the fieldwork. However, the research constituted my doctorate in social anthropology and I chose not to operate as a practitioner. Participant observation was carried out primarily amongst the inhabitants of a neighbourhood consisting of core brick housing and shack dwellings on municipally serviced and unserviced sites. I also observed regularly in the specialist psychiatry clinic at one of the state-operated community health centres, where payment is adjusted according to means. This included sitting in on consultation sessions run by the nurse and the doctor respectively. In addition, I routinely attended the meetings and activities of two free 'psychosocial' groups organized by a mental health NGO for people considered to have a medical diagnosis of mental illness. I accompanied the social worker on visits to the homes of 'clients' and observed their appointments at the clinic. Finally, in-depth interviews were completed with certain individuals whom I had come to know in these three contexts. This paper is also informed by insights gained from participation in a project examining disability grant provisioning, commissioned by the state in 2003, whilst I was a researcher for the Human Sciences Research Council of South Africa.

Background

The advent of the first democratic government in South Africa in 1994 heralded the introduction of a new constitution and Bill of Rights. The latter guaranteed the right to health, and the right to access to social security. Understandings of the rights of citizenship, notions of equity, and expectations of restorative justice and state provisioning are central to the politics of social security in South Africa. Since the democratic transition, the system of welfare provision has undergone evaluation. This restructuring process has generated competing discourses that can be seen to permeate state decisions regarding these cash payments. On the one hand there is much rhetoric about equitable allocation and increased access to grants, through greater bureaucratic efficiency and a revised system of decision-making: the overriding theme is one of the government as 'for the people', the provider of a safety net for the most vulnerable. On the other hand, there are largely fiscal anxieties about the need to 'rationalize' grant procedures in order to control the numbers of people in receipt of grants. This ambiguity is reflected in state macro-economic strategies that attempt to straddle neoliberalism and a social welfare model.

With respect to the disability grant, such tensions have been stimulated partly by a government shift to a high profile political commitment to a 'social model' of disability with respect to the allocation of grants, a shift very much in line with international disability discourse. It is argued that the new system of 'comprehensive social security' should be based not solely on an assessment of the health condition by a doctor – a system criticized for its subjectivity and medical reductionism – but on a 'needs-based assessment' by a panel including lay people. A further motivation behind panels is to improve access to grants in areas where there are no doctors. The emphasis on ensuring a means to obtain disability grants for people in the 'deep, deep rural areas' has huge political currency. Yet, commenting on the plans for a comprehensive system in his State of the Nation address in February 2004, President Mbeki also stressed that the state aimed to create the economic conditions 'to reduce the numbers of our people dependent on social grants' (Office of the President, 2004). The treasury, in particular, has advocated standardization of assessment amidst fear that lay panels will allocate disability grants as an unemployment benefit. In 2004 there was growing concern in government about a rise in social welfare spending and about the increased uptake of the disability grant, with more than a million citizens now estimated to be in receipt of this payment. Consequently politically charged debates have arisen within government, the media and the public health and disability sectors regarding who should be included within the status of 'disabled', particularly in the light of large numbers of people with chronic illnesses such as HIV/AIDS. There are calls to root out 'illegitimate' grant recipients, accused of defrauding rightful applicants and 'abusing' the system, and for the removal of 'perverse incentives' to be classified as disabled (see South African Department of Social Development, 2004). Officially the purpose of the grant is to provide an income for adults unable to maintain themselves on account of 'disability', but both this purpose and the category are now contested. Recently the Department of Social Development has attempted to buy time for reforms and stave off legal challenges by stressing the principle that the constitution makes provision for the progressive realization of rights. The government has repeatedly rejected calls for the implementation of a basic income grant to provide a universal income support mechanism. The material and experiential effects of these apparently abstract, shifting national public health policies and discourses on illness as expressed at clinic level, and their effects on the health worker–patient relationship, is the focus of the remainder of the paper.

'The nerves of suffering': understandings of mental disturbance in Khayelitsha

The ethnographic example requires some background as to understandings of mental disturbance in Khayelitsha. Accounts of the aetiology of mental disturbance and distress are most often multi-layered. Illness narratives demonstrate how local concepts (for instance regarding witchcraft and ancestral influence) are adapted to explain circumstances. Furthermore, a variety of notions have been assimilated. Such ideas suggest the influence of Christianity, biomedicine, the media and concepts current in national ideology, such as the assumptions promoted by the Truth and Reconciliation Commission. In particular, my fieldwork has revealed instances where words loaned from professional medical discourse and lay mental health concepts

(such as stress, anxiety and depression) have been transformed or resisted in the Khayelitsha context. The belief in severe social circumstances initiating or exacerbating illness operates in many accounts associated with these concepts. One such assimilated word that has gained wide currency and a range of local meanings is the notion of *iinerves*, an isiXhosa derivative of the English word 'nerves'.

In Khayelitsha, most people who have been diagnosed biomedically with some form of mental illness do not know any psychiatric name for their conditions, but frequently report that they are receiving treatment for *iinerves*, formulated as '*dineenerves*' – 'I have nerves'. The sensations encompassed by *iinerves* are often spoken about as originating in the bodily response to a single harsh event or an ongoing experience of trying life circumstances, linking in ideas of the agency, in this instance, of harmful social forces, and prompting diatribes against incompetent health professionals, corrupt municipal councillors or unconcerned national politicians. The use of the notion of *iinerves* is not limited to the accounts of people with a diagnosis of severe mental illness. Women and men who are not judged as disturbed and who have not necessarily been given any psychiatric diagnosis, but who are experiencing difficulties, will express that they have *iinerves*. Nokuzola's words encapsulate her understanding of mental distress:

It is caused by the nerves of suffering (*iinerves zokusokola*). If you want to have something and you don't have means to get it. Those things are working on you. If you don't have money, you are struggling; all those things are in your brain because there is nobody to help you. You want to be like other people and you are unable to be like them. You try but you fail. Sometimes you are at home and you don't have a husband like myself. I am struggling. I have children. Sometimes my neighbours are tired. I cannot ask for anything from them. All those things are happening to you.

This assessment in many ways reflects a number of issues central to the disorder that she perceives in her social world: the poverty, the inequality, the disruption of kin ties and the limits of 'community'.

Several scholars have analysed the widespread understandings of variants of 'nerves' in settings cross-culturally as an example of 'somatization', formulated as the symptoms of the body articulating an underlying psychic distress. The notion of somatization and psycho-somatic illness remains in psychiatric conceptualizations, but more recent anthropological literature has criticized the mind/body dualism that such understandings imply (see, for example, Lock & Scheper-Hughes, 1996, pp. 47–48). The perspective of embodiment, as proposed by scholars such as Csordas (1994), employs phenomenological ideas to foreground the primacy of bodily experience in reflecting on the disordered life world that illness can create. An attention to bodily experience has been evident in the literature on social suffering (Kleinman *et al.*, 1997) and ethnographies such as Scheper-Hughes' (1992) description of *nervios* and the 'violence of everyday life' in a Brazilian *favela*. These insights are applicable to the Khayelitsha material, where the discourse of 'having nerves' could be read as representational of a broader experience of social suffering, but equally as encompassing deeply distressing bodily sensations born of the struggles of survival in such a place.

The range of meanings that has come to be associated with 'having nerves' in Khayelitsha in many ways provides the concept with its social function. Constructions

of bodily experience come to have specific uses. This is particularly evident if one examines material gained from the observation of consultations between medical personnel and people attending a psychiatry clinic, paying attention to the vocabularies used in this setting to encapsulate distress and facilitate communication. Of interest in the section that follows is the role that such formulations play in the dynamics of grant negotiations.

The local politics of grant allocation in a Khayelitsha psychiatry clinic

The clinic context

At the community health centre where the fieldwork was done, a psychiatric nurse ran the psychiatry clinic on a day-to-day basis. The care given conformed to a noticeable routine. When I first entered the small room that served as the psychiatry clinic, it was an image of *staff* 'stress' that struck me: the nurse's desk was arranged opposite the door, with a pin-board on the adjacent wall. In the centre of this board was a drawing of an exhausted and dishevelled-looking individual, entitled 'mental health nurse burnout', with arrows and comment explaining aspects of dress and demeanour that could be attributed to the draining task of responding to the needs of 'clients'. On this morning, the mental state of the nurse bore some resemblance to that suggested in the picture. The door to the room was open, and, in the narrow corridor outside, the 'clients' expectantly lined the wall on a wooden bench. Piled high on the desk was the orange stack of folders of those still to be seen, and another pile of those already dealt with. As the morning progressed, the queue outside diminished rapidly, the nurse seeing people in rapid succession, dashing off a note in the folder and signing the medication chart, the nurse assistant already shouting out the next name with gusto into the corridor. By lunchtime, an uncanny calm settled, the pile gone, with just the occasional straggler bringing back a folder. The nurse assistant went off to a stall to buy fried chicken, which the staff now proceeded to consume with relish, the newspaper wrapping spread out on the desk. This signalled the end of the morning routine. Afternoons were a quiet affair. The exception was Monday afternoons, when a trainee psychiatrist arrived to conduct a weekly clinic. Certain 'clients', on average 22 people, would be selected by the nurses to attend. The clinic nurses were isiXhosa-speakers who lived locally, but the doctor was white and could speak only English and Afrikaans.

The most distinctive feature of the doctor's clinic was the fact that the vast majority of interactions with 'clients' occurred through translation – attendees were addressed in the third person by the doctor through the nurse. The language difference was but one constraint. The doctor and the nurse also had different ideas as to who should be referred to the doctor's clinic. The nurse, when explaining the function of the doctor's clinic, said: 'The doctor does the disability grants.'

Constructing the vocabulary of the clinic

It was evident that the language of 'nerves' and 'stress' was the common language of the clinic. Constant references were made to 'nerves' in the typical accounts of distress presented by those attending the clinic, in which clusters of sensations were

explicitly linked to their ongoing social-economic difficulties. In turn, the doctor's preferred mode of explanation was to incorporate some idea of 'nerves'. Psychiatric classifications were seldom used. The doctor seemed to have decided that the language of nerves was an appropriate mode of communication in this setting, and more easily understood. The doctor spoke of nerves chiefly as biological entities that could be affected in a variety of ways, contributing to a particular state of mind. The idea of weak, tight or damaged nerves was employed by the doctor; he would explain how medication would heal, strengthen or relax them.

Those attending the clinic used the idiom in more diffuse ways, incorporating aspects of its usage outside the hospital. Thus the typical accounts told by people in the context of the clinic as evidence of their having nerves, whilst emphasizing their bodily discomforts, were also litanies of the problems that characterized life in Khayelitsha. For example, a woman diagnosed with a major depressive disorder claimed to be distressed because her son had stolen her money and left home to join a gang of street children. She complained of neck pain and palpitations and told the doctor: 'I am sick. My nerves are high.' Usually a string of accompanying feelings followed a declaration of having nerves, such as headaches, dizziness and 'thinking too much'. The notion of nerves as analogous to 'stress' was a common denominator in interactions. A man diagnosed with bipolar disorder told the doctor: 'I am happy with the treatment but now I have stress. It is sore at the back of my neck here. I think it is stress or thinking too much.' When the doctor asked him what was 'worrying' him, he replied that he was afraid that his grant would be stopped as he had received a letter that it needed to be reviewed. Thus whilst a process of constructing understandings was dialogic, the meaning or significance of 'nerves' as employed in this clinic context by the two parties remained different, although both accepted that the word was a valid common term to use in their interaction.

The disability grant: necessity or reward?

Broader factors maintain the disability grant and old age pensions as the only hope of income for many people living in townships like Khayelitsha. The value of a disability grant is equivalent to approximately half the monthly income that can be earned from the full-time work commonly engaged in by inhabitants. It is undoubtedly hard to scrape through on this amount, especially if many people are subsisting on the money. However, it does represent a certain income. In order to obtain a disability grant (referred to as a DG) in Khayelitsha, one had to get an affidavit to confirm unemployment. A grant form could then be issued and taken to a doctor, who had to agree to complete it. Thereafter, at a central office, another doctor, employed by the province in the capacity of 'medical pensions officer', would make the final decision as to eligibility. From the applicant's point of view, however, the clinic doctor's recommendation was the powerful factor determining grant allocation. The doctor also had the understanding that he had considerable power in determining the decision at the provincial level by presenting the diagnosis in a particular way on the form. The various people involved in disability grant applications had different understandings of the purpose of a grant and which criteria should be the important factors in grant allocation. Each of these perspectives will

now be detailed in turn, contrasting the points of view of the applicants with the respective positions of the three professionals involved. The social worker, the clinic nurse and finally the doctor will be considered in turn.

Sedation, institutionalization and disability grants were the most frequent services sought from the clinic. Two assumptions were evident in the ways in which attendees requested a grant. Firstly there was the expectation that foregrounding one's suffering and pleading economic hardship would make the doctor sympathetic to signing a grant form. This translated into the belief that an account formulated as a typical narrative of nerves should have this desired effect. I heard this narrative form repeated in consultation after consultation. The second understanding was that if one was prescribed any form of medication by the doctor, or was expected to attend regular clinic appointments, this translated into having an illness and should therefore make one eligible to receive a grant.

The social worker employed by an NGO ran a psychosocial group in Khayelitsha for people diagnosed with mental illness. She understood the chief function of the DG to be the provision of an income for those who, due to their condition, would find it difficult to obtain work on the open labour market. She was active in encouraging all her clients to apply for grants, assisting them to obtain the necessary documentation to present to the doctor. She emphasized the role of the grant in poverty alleviation. There were so few jobs available anyway for people in Khayelitsha that her clients were unlikely to obtain work and, in the meantime, the struggles associated with destitution, in her experience, would precipitate further attacks of illness.

At the clinic itself a DG application was never suggested. The nurse only referred people to the doctor who themselves requested the grant and who had organized the forms at their own initiative. The nurse was a gatekeeper to the doctor's clinic and was continually on the lookout for those who, in her judgement, were attempting to 'abuse' the grant system. The formulaic nature of accounts of illness for the purposes of requesting a grant would arouse her suspicion. She would comment to me that someone was 'exaggerating' in order to obtain a DG, concluding: 'Patients and relatives make up stories for white doctors.' Thus, when the doctor refused to sign a grant form for a woman with a diagnosis of depression, the nurse agreed: 'She is manipulating everyone. Her problem is that she has no money and she is stressed.'

The nurse's attitude revealed the influence of a prevalent discourse amongst community workers that emphasized the importance of 'empowering' people to help themselves. Thus her belief was that people in Khayelitsha should firstly be encouraged to find alternative forms of income to a DG. She informed me: 'I tell the clients that they must get on and not resort to the DG. It is better if they are not on it'. Moreover, she would point out to people that their suffering was not extraordinary: the collectivization of the experience of suffering normalized individual suffering. This is evident in the following account of the interaction between the doctor and a woman, where the nurse interpreted. At the outset the doctor asked the woman if she had any problems with her medication; she responded instead: 'Doctor the problem is my children are crying from hunger.' He replied that it was depression that was making her sick and that she should keep trying the tablets. When she became tearful, the nurse underlined that her experience was not unique: 'What is happening to you is happening to everyone. You mustn't cry. If you cry in front of

the children it will make them worse.’ The nurse was irritated, commenting now in English: ‘I cannot understand them, they bring these problems to the clinic. We are not here to make things straight for them. They must make things straight with the help of their families.’

From the perspective of the doctor, the effort expended on grant bureaucracy was a source of frustration, as this reduced valuable time for addressing medical aspects of illness. On average half of the patients seen at the doctor’s clinic had some request related to a DG. The doctor bracketed off his responsibility as not extending to the amelioration of the social, expressing a fear that this could swamp his work. Thus he would cut short people’s expositions of dire circumstances and make it clear that he could not help with those, although he could prescribe pills to assist with ‘organic’ symptoms of depression, such as lack of sleep or energy. It is understandable that the time constraints of such a large clinic, exacerbated by the language and class barrier, evoked a sense of powerlessness in the face of the enormity of the problems beyond the walls of the guarded hospital compound. Such circumstances encouraged a retreat into an approach focused narrowly on individual psycho-biological malfunction, and a heavy reliance on pharmacological therapy. They also encouraged a reduction of solutions to individual and family responsibility. People were constantly urged to find their own solutions to problems – to secure jobs rather than relying on a disability grant. Structural problems, such as the high level of unemployment, were seldom acknowledged. In addition, the idea predominated that members of households should be primarily responsible for care of the ill. On one occasion a man recognized as a ‘client’ was creating a commotion outside the hospital, scratching in the rubbish bins. The nurse started to go off to fetch him to be assessed in the clinic, but the doctor stopped her. He declared: ‘We are not in the business of social welfare; we do not go out searching for patients. The community must bring them to us.’

With respect to grant allocation, severe disturbance that was not responding to medication was the doctor’s primary criterion. He would rarely initiate discussion about a grant, and if he did it was for use as a bargaining strategy. The most explicit exercise of power in the clinic involved firstly the withholding of disability grants until people complied with the medical regime of attendance and treatment, and secondly the granting of DGs as rewards. In the first instance the doctor tried to coerce people into attending the clinic and collecting medication for three consecutive months before he would consider signing the form. In the second, DGs were at times given as rewards to those who were commended for making an effort to improve their circumstances, or to gain ‘insight’ into their condition, namely understanding of the psychiatric view. These people were considered the ‘deserving patients’. The ‘undeserving’ were the ‘irresponsible’: those who continued to use drugs or alcohol, and did not take medication or attend regularly. The following accounts of the consultations of two people seen directly after each other in the clinic illustrate this assessment.

The first ‘patient’ seen was introduced to me by the doctor as someone who was ‘studying and looking for a job’. He could speak English, was attending university and was receiving counselling there on account of his illness. He was unmarried and lived with his mother, who had a stable income as a domestic worker. He attended the clinic regularly and was now requesting a DG. The doctor told him that he would

give him a grant because, in the doctor's words, he felt this supplicant was 'worthy'. Strictly, the doctor told him, he did not qualify as he was functioning well and might get work but, 'it is not really lying. It is helping you.' The doctor then justified his decision to me, explaining: 'He is schizophrenic and he has even been admitted before. However I can see that his request for a DG is openly socioeconomic. But he has been trying to get a Bachelor of Arts for six years. It is hard enough to fight out of a situation like this without the economic problems.' Here the DG was ostensibly given for financial need, a decision which the doctor felt was irregular and not an adequate reason alone. However, it is clear that notions of worthiness were more complex. The doctor had the idea that giving a grant to this man, who seemed more likely to go somewhere, was a worthwhile investment.

After this consultation, the next person sat down and unleashed her stream of misery: her heart was painful because her mother had had a stroke and her brother had died in an accident. She was unemployed and trying to support three children. The doctor cut her short and told her through the interpreter that she needed to do something like join a church, or spend more time playing with her children. He added: 'All these problems, including the physical complaints, will be solved if she gets work. I can give her tablets for energy and to help with sleep, but she can't wait for tablets or a grant. My tablets will not fix the money problems. She will continue to feel like this if she doesn't start now to find work and take responsibility for herself to solve her problems.' The doctor explained to me: 'She has chronic depression. There is learned helplessness. It is a double bind because as soon as I lower my prescription threshold the patient presses for a DG.' The woman in fact asked the doctor angrily how he could prescribe pills for another six months but not give a DG. The nurse assistant shooed her out, declaring: 'This patient is always trying to present her condition seriously because she wants a DG.'

It is apparent that the expectations of people presenting with 'nerves narratives', namely to have their economic needs addressed by the state in the form of a grant, were usually not met. In fact, an explicit request for a grant on account of financial need was considered in a negative light by the doctor. In the minds of the applicants he personified the intermediary and advocate for their receipt of state aid. It is here in these encounters that the disjuncture between the priorities of the doctor and 'clients' was most striking.

Changing grant criteria and the local construction of knowledge about an illness

To add to the complexity of the politics of healing practice in the clinic, the disability grant system was in some disarray at a provincial and national level at the time of this study. The province was in the process of 'rationalizing' grant allocation, so that all those in receipt of grants were being notified about reviews. Several disability grants were not renewed on re-application, and others were simply stopped without notice. Different application forms were circulating and there was uncertainty as to how criteria were now being applied with respect to different kinds of mental illness. This uncertainty existed on the part of professionals and applicants, some of whom were being told by the doctor that their particular diagnosis would probably no longer qualify them for a grant. Such changes were not only deeply confusing to

those affected: shifts in criteria for grant allocation were influencing understandings of the nature of illness and of responses deemed appropriate.

In the meetings of the mental health NGO's psychosocial group there was much discussion about the different ways of conceptualizing mental disturbance and the implications of the changes in grant criteria. For example, during one meeting Mzoliswa commented that he had heard a radio programme about depression (*idepression*) and had thought that this description corresponded to his experience. He in fact had a clinic diagnosis of major depressive disorder, although he told the group he had never before heard of 'depression'. In his own account of his illness, Mzoliswa suggested that he had also considered that he might have *inerves*, because people 'in the community' said that he had nerves because he 'liked to be alone'. He knew that he had some 'mental sickness' as he put it, as sometimes he would wander around not knowing where he was.

The DG became Mzoliswa's main concern. He was told by the doctor, during a consultation in mid-2000, that the government was no longer giving grants for 'depression' and that he therefore could not expect his grant to be renewed at the next round of reviews in three months time. He was warned that he needed to start looking for work so as not to be caught off guard. When I spoke to Mzoliswa after his clinic appointment, this information was worrying him greatly, as he had a wife and child to support. He seemed to be under the impression that when his grant ceased, his medication would also be stopped. He was worried that he would get 'sick' again, and also pointed out that he could not sleep without the medication. He raised the issue of the grant at the psychosocial group, explaining that he did not understand if the doctors thought he was sick. The social worker explained: 'You are all sick, but the symptoms differ. But the government is not going to give a grant for depression because this illness it comes and goes and if you talk about it and get it out, you get better quickly.'

The social worker's explanation that depression was easily reversible did not reflect her true feelings. She said to me after the group: 'Things are becoming so tough now. Why doesn't the government consider depression as a mental illness anymore? So now us social workers must push these people into the open labour market before their grants get stopped and they get even more depressed.' The nurse's comments on the changes in policy also indicated that she sympathized with 'clients' who found it hard to make sense of the new criteria. She told me: 'With the previous government we didn't have all these problems like depression not getting a DG. But with the new government it has changed.'

In this way changes in grant allocations were shaping the local conceptualization of illnesses. In the case of depression, it raised questions about its existence as a 'real' illness, and explanations given in justification for the government's decision shaped ideas about the manner and ease in which such a condition could be dealt with.

Conclusion

This paper analyses an example of illness experience in order to reflect upon conflicting national discourses about grant allocation in the post-apartheid state. Local social practice and the strategies to secure disability grants through the

presentation of 'nerves narratives' in a psychiatry clinic have been considered. National level policy ambiguity is mirrored in the clinic politics of grant negotiation, in particular in the way in which local expectations of state welfare provision in the form of grant receipt were not often met in practice. In the decision-making of the doctor, people encountered a reflection of the neoliberal ideas representative of the other face of state discourse about grants. The ethnographic material demonstrates how these discourses at the state level played out in the ways in which doctors mediated diagnoses and furthermore affected the presentation and experience of suffering. The use of examples from one ethnographic setting – far more than just anecdotal evidence – provides valuable detail of local experience. This enables linkages to be made between the international, national and local contexts in order to illuminate what has become a complex public health issue. In conclusion, the study shows that this local/national interconnection is also evident in the way in which the global human rights discourse, as applied to health, has come to be interpreted in Khayelitsha.

In a statement on behalf of the African National Congress (1996) on the occasion of the adoption of the new constitution, Thabo Mbeki connected the notion of human dignity to economic sufficiency, and alluded to the commitment of the state to some form of restorative justice. Jensen (2001) contends that in the aftermath of gaining power the post-apartheid state constructed an identity as the keeper of the 'national democratic revolution', that includes obligations of provisioning to 'the people'. Wilson (2000) makes a similar point that the adoption of a firm commitment to a global discourse of human rights in South Africa was central to nation-building and intended to serve the purpose of a 'social glue'. He pays particular attention to local reformulation and also rejection of this 'central discursive genre of the new South Africa' (ibid. 87). Cowen *et al.* (2001, pp. 11–13) have suggested that the local negotiation and interpretation of a rights discourse can be viewed as a cultural process: a construction of understandings through local practice.

Returning to the material presented in this paper, it is possible to see how the notion of health as a human right comes to be interpreted in a place like Khayelitsha in the face of local socioeconomic realities. Kistner (2003, p. 3) points out that the right to health has often been linked back to what is considered the most basic of rights: the right to life. Have local notions of a public health prompted people to construct situated understandings of the rights discourse: a local 'rights talk' (Mamdani, 2000) that is as much about the right to a life of a particular kind, as it is about practical issues such as access to social security and health care?

An understanding of the impact of severe social circumstances on health is integral to a broad conceptualization of 'public health' in Khayelitsha. Furthermore, notions of health as a social right of citizenship, a political entitlement, are translated into expectations that the state will provide the means to health. In the 'rights talk' in places like Khayelitsha, this translates into the expectation of receiving a tangible thing from the state, such as a monetary grant to buy food, the most basic means of sustenance. As one man told me: 'The grant is what I eat.' Such expectations are congruent with the government's social welfare rhetoric, born of a socialist struggle discourse. Furthermore, the state has promoted ideas of the appropriateness of restorative justice in the monetary payments handed out to identified victims of

apartheid. It could be argued that this has further strengthened an assumption that people can expect compensation for severe, and potentially also for ongoing, suffering.

How then does the experience of 'having nerves' frame notions of the right to health or life? 'Nerves' embodies a lived experience in this place and, in its medicalized form in the clinic, becomes a discourse that also articulates connections between the life world of Khayelitsha and the national arena. The body politics of 'nerves' in the clinic bridges the gap between a local political discourse about the genesis of illness, and a medicalized discourse that provides the potential means to operationalize ideas concerning expectations of state grant provision. Yet, despite the self-initiated medicalization of 'nerves' in the clinic context, the gains for individuals were not great. The prevailing assumption and suggestion by health professionals in the clinic of individualized solutions to 'nerves' was more limited than the notion of 'having nerves' that still has currency beyond the clinic. Here, while still employing the framework of illness, the meanings continue to include comment on the lack of political attention to the structural problems that people perceive to exacerbate life circumstances and affect well-being. It is not surprising therefore that the body politics of nerves still incorporates a political critique – a reminder of failed expectations.

However, with the advent of AIDS, the sheer enormity of numbers could further overwhelm expectations of grant provision. A prominent social movement – the Treatment Action Campaign – has harnessed a global human rights discourse and effectively challenged the state to provide anti-retroviral therapy on the grounds of a constitutional right to access to health care. It is pertinent to consider how understandings of 'health citizenship' might continue to evolve in South Africa. The example of HIV/AIDS illustrates the effectiveness of a social movement organized around challenging the state on the provision of rights and employing a political discourse about inequality and health. It remains to be seen whether such social movements will emerge also out of the more diffuse experience of distress and ill health as experienced at the margins of the state.

References

- African National Congress** (1996) Statement from Deputy President Mbeki on the occasion of the adoption of 'The Republic of South Africa Constitution Bill 1996'. 8th May 1996. <http://www.anc.org.za/ancdocs/history/mbeki/1996/sp960508.html>.
- Cowen, J., Dembour, M. & Wilson, R.** (eds) (2001) Introduction. In *Culture and Rights: Anthropological Perspectives*. Cambridge University Press, Cambridge.
- Csordas, T.** (1994) Introduction: the body as representation and being-in-the-world. In Csordas, T. (ed) *Embodiment and Experience*. Cambridge University Press, Cambridge.
- Jensen, S.** (2001) The battlefield and the prize: ANC's bid to reform the South African State. In Hansen, T. & Stepputat, F. (eds) *States of Imagination: Ethnographic Explorations of the Postcolonial State*. Duke University Press, Durham.
- Kistner, U.** (2003) *Commissioning and Contesting Post-Apartheid's Human Rights*. Lit Verlag, Munster.
- Kleinman, A., Das, V. & Lock, M.** (eds) (1997) *Social Suffering*. University of California Press, Berkeley.

- Lock, M. & Scheper-Hughes, N.** (1996) A critical interpretive approach in medical anthropology: rituals and routines of discipline and dissent. In Sargent, C. & Johnson, T. M. (eds) *Medical Anthropology: Contemporary Theory and Method*. Praeger Publishers, Westport.
- Mamdani, M.** (ed.) (2000) *Beyond Rights Talk and Culture Talk: Comparative Essays on the Politics of Rights and Culture*. David Philip, Cape Town.
- Mash, B.** (1996) *Khayelitsha District Annual Report for 1996*. Health Information Systems Pilot Project, Khayelitsha District.
- Office of the President** (2004) *State of the Nation Address. Houses of Parliament*, 6th February 2004. URL: <http://www.anc.org.za/ancdocs/history/mbeki/2004/tn0206.html>.
- Scheper-Hughes, N.** (1992) *Death Without Weeping: The Violence of Everyday Life in Brazil*. University of California Press, Berkeley.
- South African National Department of Social Development** (2004) Statement issued for media release: *Minister Expresses Serious Concern about Reports of Abuse and Fraud Related to Disability Grants*, 29th January 2004.
- Wilson, R.** (2000) Reconciliation and revenge in post-apartheid South Africa: rethinking legal pluralism and human rights. *Current Anthropology* **41**(1), 75–98.