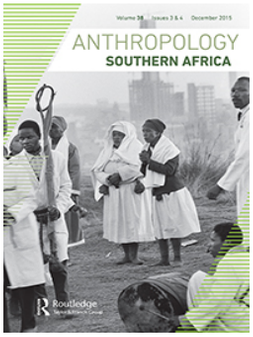

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Embodied urban health and illness in Cape Town: children's reflections on living in Symphony Way Temporary Relocation Area

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This paper explores ideas about health and illness held by six children who live in the Symphony Way Temporary Relocation Area in Cape Town, South Africa. The research shows that solutions to illness and health problems held by low-income populations are critically shaped by various characteristics of society — the surrounding neighbourhood, the family and the experience of the individual child. This contests current policy assumptions that solutions to wellness are not located within the lived experience of local populations. The findings are part of continued efforts to investigate how health is negotiated in low-income areas, what challenges people face and how they overcome such challenges. The research discusses ideas of health embodiment in relation to both the socio-economic and natural environment, and illustrates the impact that poor housing-quality and access to health care services have on health and ideas of health and illness.

Keywords: children; embodiment of health and illness; health; housing quality; low-income areas

In 2004, Edith Chen argued that in many countries people living in low income-generating areas have poorer health compared to individuals with a high socio-economic status. She said that this measurement remained valid whether one was assessing health in terms of the prevalence rate of illness, the degree of illness and/or the likelihood of death from illness-related causes (Chen 2004). Other researchers take the opposite position, arguing that "[h]ealth is much more than the absence of diagnosed physical disease" (Phillips and Verhasselt 1994, 3). The World Health Organisation (WHO) similarly understands health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 2006).

It is now increasingly recognised that health and illness and the methods employed in the pursuit of health are economically, historically and culturally located (Helman 1984). Perceptions of health and illness are influenced by structural elements (such as time, spatial dynamics and environment) and socio-economic elements (class and community transmitted beliefs). In their expanded definition of health, Phillips and Verhasselt (1994, 3) argued that health lore, the way people speak about health, involves "complex interactions between humans and their environments, more particularly between social and economic factors, physical environment and biological environment" and that this was essential to understanding urban health realities. Operating with the lens that Trevor Hancock (1992) uses in explaining health in the city, health presents itself within a unique subset of socio-economic realities. For Hancock, each city or community has its own understanding of health and its own particular context within which that definition operates, reflecting its urban conditioning (Gillespie 2014).

In this paper, I analyse what underpins health and health lore amongst children living on the margins of an urban centre. Nestled amidst the barren sand banks on the outskirts of Cape Town and next to its airport, the government built a temporary relocation camp called Symphony Way Temporary Relocation Area (TRA). Residents quickly renamed this expansive stretch of structures made of corrugated iron sheets "Blikkiesdorp" [tin can town], shortened to "Blikkies." While some

Blikkiesdorp residents are refugees, asylum seekers and immigrants, most are South Africans who had been evicted from public land to wait for government subsidised housing.[1] When I first entered the gates of the camp enclosure, I was struck by the silver, grid-fashioned, six-by-four meter shelters that exposed the realities and pressures of urban poverty, where thousands uncomfortably waited for long-promised government-subsidised brick housing. Whilst providing shelter for thousands of people, TRA sites such as Blikkiesdorp provide inadequate housing and subsequently compromise the residents' quality of life.

Section 26 (1) of the South African Constitution states that everyone has the right to adequate housing. However, "adequate housing" is not easily definable in practical terms. According to the city of Cape Town, Blikkiesdorp "was developed in terms of the National Housing Programme for Housing Assistance in emergency circumstances, and residents receive far more services than the minimum basic requirement" (Communications Department 2010). The government measures adequate housing in terms of access to services, while residents often refer to adequate housing in relation to safety and health. Yoking these two perspectives together is central to the WHO's 2010 call for official international guidelines on "healthy housing."[2] In its documents, the WHO draws a direct link between housing and health, a landmark decision in addressing poor health in poor urban areas. As it remarks, "[r]espiratory and cardiovascular diseases from indoor air pollution; illness and deaths from temperature extremes; communicable diseases spread because of poor living conditions, and risks of home injuries" (WHO 2010) are the main health challenges faced by populations living in poor-quality housing.

While the divides between those who have access to health services in Cape Town and those who do not are articulated in various ways, there are burgeoning pressures on the city to achieve an equality of services for the city's population (cf. Breckenridge 2005). It is in this context that the South African Netherlands Research Programme on Alternatives in Development (SANPAD), under the stewardship of the Children's Institute at the University of Cape Town, funded an extended arm of my fieldwork in Blikkiesdorp from October 2010 to October 2011.

Against the background of a failing public health system and inadequate housing provision in Blikkiesdorp, I chose to focus my research on how people talked about health, in terms of what I call "health lore", and on the alternative solutions to care that they developed. I found that paying particular attention to children's reflections on illness, and the subsequent solutions they found, provided a powerful insight into how public health care systems could begin to imagine better access to health services for those moving in and out of the public health system in Cape Town. Children's experiences foreground choices, ideas and conceptualisations of health shaping the city-scape of Cape Town, as a composite whole comprised of different "vectors and tensions" (Gillespie 2014, 203). This understanding provides a compelling narrative of lapses and glitches within the healthcare system (Gilson and McIntyre 2007) that are arguably rooted at different points along the historical trajectory of South Africa's public healthcare system (Coovadia et al. 2009).

The bulk of the qualitative research outlined in this paper was generated from requesting the children to express their experiences and feelings by designing a body-map (Figures 1 and 2). This body-map was accompanied by several semi-formal interviews that provided insight into how children experienced health and illness in and with their bodies, and their lives through and within the Blikkiesdorp relocation site.

Methodology

This paper considers and examines the perspectives on health,[3] healthy living and housing of six children from Blikkiesdorp. The questions posed to Matla[4] (14 years old), Sameerah (14), Laelynn (15), Gabriel (14), Aalif (15) and Jafari (13)[5] required them to reflect upon how their home environment and recourse to health care affected their health, and also broadly probed what they understood by and about health.

For the research I used a methodological approach that I called "Creative Education," the

objective of which was to allow the creation of listening spaces by having the research participants engage in creative processing.[6] The creative process was designed around particular themes taken from anthropological theory. It allowed the children participants to produce collages, creative writing, permaculture design gardens, a theatre and performance piece, and a large body-map. For this, the children drew and painted a large body and vividly described how they felt the illnesses they were drawing on their bodies. These images, and the way in which the children talked about them, provided a space for listening and allowed an understanding of the sense the children had of health in relation to their environments.

The research approach echoes Nigel Rapport's concept of "poiesis" (Rapport 1987, 188), a term he uses to describe individual creativity or the creative force that determines the nature of lived experiences. Following Sartre, Rapport explains that, although an individual is born into a specific sociocultural and contextual historical framework, the person is the craftsman of meaning construed as his/her knowledge. This ultimately means that an individual is able to reimagine his or her life and knowledge beyond sociocultural prescription. An individual therefore "is responsible for the sense he makes out of [the historical conditions he finds himself in], the meanings he grants them … In short, he might be surrounded by the 'actual facts' of an objective historico-sociocultural present, but he can transcend their brutishness, surpass a mere being-in-the-midst-of things, by attaining the continuous possibility of imagined meanings." Implicit in this meaning-making is a sense of continuously contesting boundaries, consistently "going beyond" (Rapport 2002, 33) the margins of space, place and time.

Rapport's (2002) emphasis on individual creative wisdom underscores the usefulness of creative projects as a methodological approach. I felt that the creative elements of this methodology lent themselves most powerfully to eliciting children's experiences and insights. These would allow a window into the realities of people living at low socio-economic levels and those of people living in TRAs in South Africa.

The collective body map they created served as an entry point to understanding the merging of the children's bodily experiences of place and senses of health. The children illustrated and marked pain and injury on the body through textured lines and shapes, filling in their experiences with bright colours that immediately drew the viewer's attention to the various illnesses experienced by children and the way they narrate these experiences. The colourful strands of meaning that were laid down and spoke visually told a story of the wealth of knowledge about health that many residents of the Blikkiesdorp TRA have. The conditions of the children's homes and the surroundings in which they lived impacted tremendously on their reflections about their lifeworlds.[7] Respiratory ailments and skin maladies (like asthma and eczema), which the children identified, are characteristic of illnesses exacerbated by poor housing quality, such as those found at Blikkiesdorp (WHO 2010). Listening to children's reflections on their experiences with illness and health highlights three important and interwoven research topics. The first is the effect of structural inequality on experiences of health and illness. The second explored approaches to health care, which included an examination of the strategies that people adopted to deal with their illnesses and come back into health. The third topic is the presence of multiple figurations of childhood (Castaneda 2002) in the everyday. This research breaks from the existing assumption in the literature that children are passive recipients of their worlds (Prah 2013) and rather makes a contribution to the idea that children can themselves reflect directly, incisively and excellently on both social conditions as well as political and economic climates. The research presented here builds on current figurations of children as agentive members of society and takes the debate further to argue that children's perspectives are on par with reflections provided by adults within society. Indeed, the findings sourced from children's stories reflect a nuanced commentary on the socio-political and economic realities of the vast majority of South Africans.

The exploration in this paper draws extensively on quotes from the interviews with the children to illustrate the nuanced commentary they provide of the socio-political and economic realities that the vast majority of South Africans lives in.

Situating health in place

Blikkiesdorp is a relatively new temporary but formal settlement in the township of Delft, 34 km from Cape Town's city centre and adjacent to its international airport. It comprises about 1600 one-room structures, but has no schools or health facilities within its boundaries. It is surrounded by a concrete fence so that residents have to access it via one of only two gates. Blikkiesdorp was built by the N2 Gateway Housing Project[8] as temporary accommodation for residents of informal settlements in Delft and other parts of the city who were on municipal waiting lists for free government housing. At completion, the N2 Gateway Housing project promised to deliver approximately 25 000 housing units along the N2 highway in the Western Cape, built in three phases, "70% of which will be allocated to shack-dwellers, and 30% to backyard dwellers"[9] (Chance 2008). However, from the outset, the Project was compromised by muddled legal wrangles, controversial evictions and messy protests.

To begin the N2 Gateway building process, mass evictions along the highway were initiated in 2006 with the promise that those evicted would be allowed to return when the units were completed. As part of Phase 1, approximately 1 000 of 20 000 residents (children included) living in Joe Slovo, an informal settlement located about 12 km from Cape Town city centre along the N2, were moved to Thubelisha (locally also known as Tsunami), a TRA in Delft.[10] Despite the major structural problems of Phase 1, the threat of mass evictions was not lifted from Joe Slovo. The remaining 19 000 shack dwellers were charged with illegal occupation and threatened with eviction to Delft's TRAs in preparation for Phase 2 that would extend *in situ* in Delft. In 2007, backyard dwellers from Delft, Belhar, Elsies River and Bonteheuwel moved into the unfinished homes that were part of Phase 2 but were eventually evicted to join thousands of displaced people.[11] In 2008, Blikkiesdorp opened its gates and became the third TRA in Delft, providing emergency shelter to all those displaced by province-wide government evictions and also those affected by the xenophobic violence of 2008. In 2011, the Constitutional Court revoked its earlier eviction orders but this meant little to the thousands of people who were already dislocated. Despite the promises that the new N2 Gateway housing was being built for removed residents, many have spent years in Blikkiesdorp (and TRAs like it) and have not been able to return to their former homes. Wider problems facing the removed residents are the bad building quality of the new N2 Gateway units, corruption and mismanagement in the running of the N2 Gateway project, as well as uncertainty and disputes about who would be allowed to inhabit the new N2 Gateway units.[12]

The removal and temporary dislocation of people from various informal settlements to Blikkiesdorp had significant consequences for them: it affected children's school attendance, people's access to transport and disrupted existing networks of support. For many children moved, Blikkiesdorp has come to represent home as this is the place in which they have spent more years waiting for the long-promised brick housing than the areas they have been moved from.

Besides these social and economic disruptions, Blikkiesdorp also offered little by way of health services. The nearest health facility was the Delft Day Hospital, situated about 1.7 km from the entrance gate of Blikkiesdorp. For more serious health issues, patients were referred to the Tygerberg public hospital, located about 17 km to the north-west of the TRA in the suburb of Parow. Most residents of Blikkiesdorp had better access to health facilities in the informal settlements from which they hailed. The issue with health facilities near Blikkiesdorp, as the data discussed below will show in greater detail, is, however, that they were not maintained or cleaned, and were badly managed, leading to long waiting hours for patients and the inability of health staff to deal with emergencies efficiently and timeously. In 2014, the Council of Cape Town decided to build a new health facility about 2.8 km outside of Blikkiesdorp, to offer health services including

x-ray facilities, a dental clinic and an office to monitor and diagnose communicable diseases (Council of the City of Cape Town 2014), a clinic which might address the health service problems identified in this paper.

The problems of the existing health care system as well as of access to it were identified by the children of Blikkiesdorp in a number of interviews. The following extracts identify the most important ones. In answer to a question about the cost of accessing public health care facilities, the children replied:

> Efua: So do you have to pay to go to hospital?
>
> Sameerah: No, only if you have an income or you have to go for an operation. They ask you when you make a folder if you have an income. If you get grants, then you don't need to pay. If one person is working in the house, then you don't need to pay. But if everyone is working and you get a grant, then you have to pay something. But Tygerberg [hospital], when I was there on Thursday, I saw that people is paying and they get a slip also.
>
> Gabriel: That's for operations and stuff.
>
> Sameerah: Then I see lots of people is giving money and it's a lot of money … yoh! But Tygerberg's toilets are *vuil* [dirty and disgusting]. [They all laugh]. It looks nice when you go into the hospital, but then if you go to the toilet-pot — *jy*, it stinks and it's dirty! There my mommy and I were sitting the whole day with a pee. We only came to pee here at home because it's too dirty.

This quote reflects not only on the cost of health care, which is a positive evaluation, but also on the level of hygiene in health facilities: paradoxically these run counter to the ethos of what health facilities combat — illness and contagion. The presence of dirty toilets within the setting of Tygerberg hospital poses a serious threat to health seekers. Sameerah and her mother's choice to wait for their return home to relieve themselves provides a telling tale of the scope of health hazards that residents of low-income areas need to negotiate.

In the following, the children reflected not only on the difficulty of physically accessing a health facility, but also the bad level of service received there:

> Efua: Is the hospital [Delft Day hospital] far from here?
>
> Sameerah: Yoooh, Efua!
>
> Matla: It's not far but it takes long!
>
> Sameerah: *Ja* [Yes], it's not far but it takes long!
>
> Matla: When you get there, you have to take hours and hours … yooohhhhh! [He smiles and shakes his head]
>
> Sameerah: And here, you can die by this day hospital [Delft Day Hospital]. If you go in there now [at 12 midday], Efua, you'll see it's full house! You'll come out 8 o'clock or 9 o'clock [in the evening]. One morning, my mommy was sick, so she went to the day hospital so early I hadn't woken up yet to go to school. My mommy came here back in the night at 12 o'clock. She lost a baby already at this day hospital because they take long. The baby after me. They took too long. She had a still-born. My mom's like this: She is pregnant then she starts bleeding early. I was also supposed to be dead, also Shameela [her little sister]. So that time they saved us, they cured the blood. But with that baby, they took too long. Here, by this day hospital, you will be under pain but you still have to wait. Even if you go there by emergency, you will sit and wait for hours. The doctors there [are] taking their own time. Then they even walk slow when they come from a break. They walk slow! They don't care. And it's dirty! And also now you don't have money and you're very, very sick, it's an emergency, then you have no choice. You have to go here. And it [already] takes long to go to [the perimeter] gate [of the TRA], if you walk [from the house]. And then you still have to walk so far [from the gate] to the day hospital.

The children identified a further limit in the access to health facilities, namely the socio-environmental complication of violence that limits the frequency and possibility of residents of low-income areas in Cape Town seeking health care (Gillespie 2014):

> Gabriel: And they still rob you, they want [to] kill you and take your money.

> Sameerah: Even if its daylight, they rob you. If you don't have something on you, then they hurt you, even if you're in pain walking to the day hospital.
>
> Efua: Who is "they"?
>
> Sameerah: The gangsters. They stand here by this ditch place. You have to go down, now they are waiting for you there. You have to go down [there through the ditch] to go to the day hospital. And there's running rats up and down.
>
> Laelynn [laughs]: My mother is scared to walk there.
>
> Gabriel: I was going here to this day hospital and there was a boy walking with his girlfriend in front of me to school. So these two boys stabbed this boy, there in front of me, there in the ditch. They were supposed to walk past the day hospital, but instead they now had to walk in.
>
> Sameerah: They took him to Tygerberg hospital. He was laying there for 4 days. They stitch him. You can still see it. It's ugly. He always shows it. He was in pain.

There are a few layers to read into what the children shared. First, the issue of access to transport impacts the experience of health care, in particular regarding access to the services at Tygerberg Hospital. In addition to being quite far from Blikkiesdorp at 17 km distance, public transport does not travel the shortest and most straight-forward route to the hospital and households with monthly incomes lower than R2000 a month have to pay for the longer journey. Some people do walk the distance, but this is difficult to do with an ailing body. Second, the long wait for adequate care, both at Tygerberg and at the Delft Day Hospital, is often exacerbated by the "weight" of death in the waiting rooms. Third is the issue of safety in accessing health care and the experience of violence. While violence is a constant feature in every-day social interactions (Prah 2013), seekers of health care are confronted with it in particular when accessing health care at the Delft Day Hospital. The path that a foot-traveller has to take to reach this hospital is a gauntlet of criminal activity which forms a serious obstruction in the access to health and well-being. Sameerah's last comment leaves a bitter taste. She eloquently reflects the young boy's scars of bravery that he flaunts as testament of his triumph over pain and violence wrought against the body.

Embodiment: the social and the physical

Central to this paper's argument is the understanding that the body interpenetrates and interacts with the environment in ways that create multiple meanings within changing landscapes. In recent anthropological literature, "lived bodies have begun to be comprehended as assemblages of practices, discourses, images, institutional arrangements, and specific places and projects" and are "[s]een as contingent formations of space, time, and materiality" (Lock and Farquhar 2007, 1). This loosening of the definition of human bodies to include their environments and experiences has many precedents in the anthropological literature (see Mauss 1934; Douglas 1966, 1973; Scheper-Hughes and Lock 1987; Synnott and Howes 1992). Building on the works of Heidegger, Merleau Ponty and Pierre Bourdieu, Thomas Csordas (1990) argued for a phenomenological approach that signalled a move away from understanding the body as a subject to which things happen, to focus on the essentiality of "being in the world." Cecilia McCallum's ethnography of the Cashinahua (Huni Kuin) of Brazil and the Peruvian Amazon extended this definition in ways that I found very useful in my own fieldwork in Blikkiesdorp. Among the Cashinahua, life gives service to "a body that knows" through material, linguistic and spiritual processes (McCallum 1996, 347). Here, health is seen as an on-going process while a healthy body is the accumulation of living and learning/learned senses. The Cashinahua's epistemic basis of bodily knowledge is represented as living knowledge where the bodies are "grown" through knowledge; knowledge shared through various socialisation avenues/processes from material things to spirituality and language. These processes are weighted with ideas of gender roles, kinship ties and morality. It is also understood that the body is continually being fabricated out of the environment both materially and socially. This type of epistemology is based on the knowledge accrued through a series of tangible and intangible inscriptions lived during the course of one's life as the body "comes into controlled

contact with aspects of the environment in their material, verbal, and sometimes spiritual forms." What is apparent is that the body is not only "the biological bearer" of social symbolism, but is rather the locus of the construction of sociality (McCallum 1996, 348).

In Cashinahua bodily epistemology, similar to some of the stories children living in Blikkiesdorp shared, the body is bound to lived experience. What is most essential in this reading of the body is that the children reflected a detailed and nuanced embodied knowledge of both the physical and social environment, relating their experiences with reference to living in a healthy home — a feature they understood to be essential to health and wellbeing.

Mapping health on the body

Laelynn tentatively picked up a piece of chalk and shaded in a large area on the outlined body they were drawing (Figure 1). She had broken her arm in 2007 and, on the body map that lay before her, she filled in parts of the left arm that she remembered as being bandaged up. She said that when it got cold, she could feel her arm hurting. To remedy this, her mother gave her a "pain tab[let] and rub[bed] a white cream found in a green container on [her] arm" (paracetamol and menthol

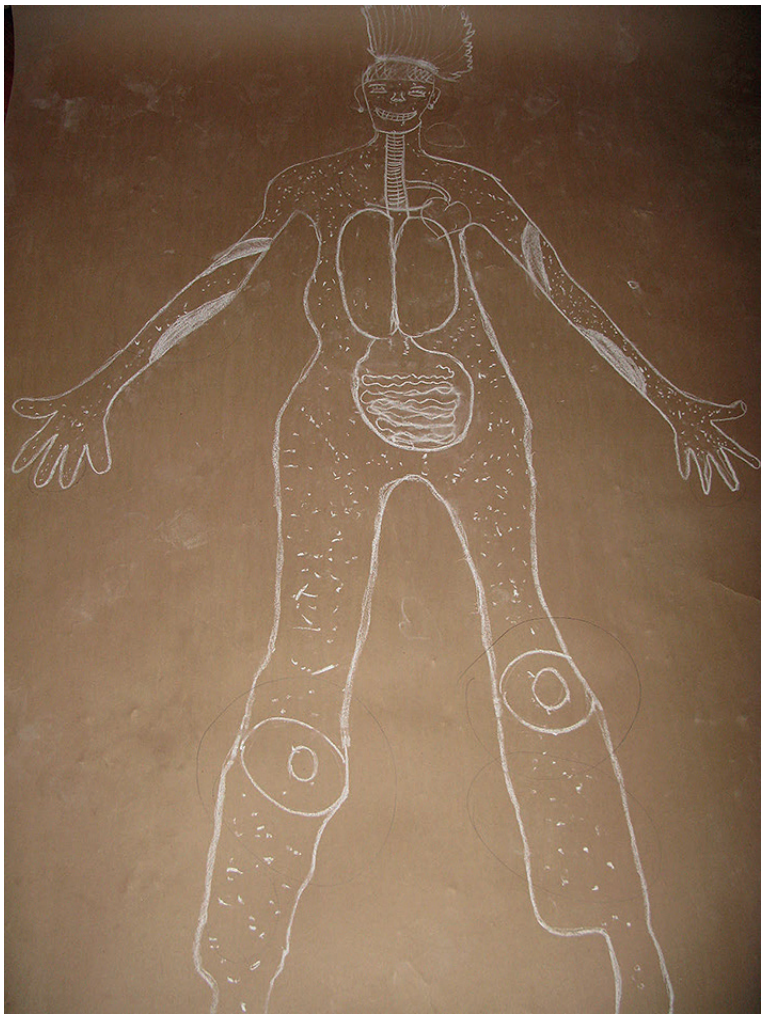

Figure 1. Tracing illness in chalk

camphor cream). Laelynn said, "You can rub it on for anything — colds and flus — and you can use it as a pain reliever." She also regularly had stomach pains, which she described as "sharp, like a needle in your skin" that she remedied by drinking "a mixture of vinegar and sunflower oil." Aalif, who said that walking around a lot caused him pain, circled the knees in the body map. Rubbing wintergreen ointment (a herbal remedy obtained at the pharmacy)[13] that smells "like bubble-gum" or "mixing some zinc with a bit of Grandpa"[14] eased the pain. All the children had already had influenza, which they agreed should be indicated as a shaded part on the head of their body map.

With slow and deliberate movements, Faizah started adding dots all over the chalk body, softly speaking of her experience of chicken pox. She said her whole body had itched and she had had spots all over her body. She said that she had spent one week at home getting well again. The other children remembered having chicken pox too. Sameerah recalled having had a fever and having felt sad while she had chicken pox. "You can't touch anyone because it can spread quick." Both her parents and the doctor had informed her about the highly contagious nature of chicken pox. She now explained, "You must go to the doctor when you have it and he gives you Calamine lotion[15] to put on." After the children finished tracing their illnesses on the body with chalk, the paper was cut up into pieces and each child received one section to paint (Figure 2).

The body-mapping stories which the children shared show how the body houses both the direct interplay of extreme weather on old illnesses and the indirect interaction with the social world. When it is cold, broken bones relive the memory of pain in the body, and when you are ill with a contagious disease, "you can't touch anyone" for fear of spreading your illness. Being quarantined from friends makes the experience of illness all the more saddening and interruptive of social relationships. The children's social experience of illness marked the inclusion of the sociological aspects of the body.

In terms of the environment, and specifically the TRAs and their impact on the health of the body, the children's discussions revealed descriptions of a range of socio-economic realties and of the physical and social activities of human beings inhabiting a particular space and time. In this regard, Aalif's reflections point to his accumulated learning and learned senses as part of his reflective writing:

> Here in Blikkiesdorp people live very difficult [lives] because here is different religions. Here is no roads. Here is no gravel roads. Here in this place, you get nothing that you need. Some Fridays or even during the week they drink alcohol, then if they drunk they begin to fight and swear. When it is hot, people cannot take the hotness, and some people get sick from the hotness.

Aalif's statement reveals the close link between body, mental and emotional growth that establishes the epistemology of life on the margins and further points to the infrastructural challenges brought on by an over-burdened socio-economic system. Hence, when the children speak of their bodies, their internal and external environments weave themselves into their lived experience. For instance, on reflecting about a day at school, Jafari said, "I'm getting burnt by the sun, because [the teachers] make us stand a lot outside. They leave us outside while they go in for meetings. I don't like sunburns because it damages my face and eats my skin off. It made another boy's face dirty; his skin was falling off." Their descriptions often infused an embodied experience of their surroundings. Another example was related to me by Aalif who had spent the day walking to and from school, to shops and public transport (activities that Aalif does to save on transportation costs). Aalif complained that the walking had placed pressure on his knee joints resulting in severe pains.

Defining health and home

When asking the children what they considered health to be, Matla replied that health was "like, looking after your body. Like doing more exercises and eating healthy … and like not smoking."

Figure 2. The painted body

The discussion gathered momentum, revealing the intricacies of the effects bad health choices (like smoking and drinking in excess) have on the body. Matla continued, "Smoking affects your lungs and alcohol affects your digestive system." When asked how the body is directly affected by drinking alcohol, Sameerah explained slowly, pausing in between sentences to ascertain that I was following her lead:

> Sameerah: When you now eat or drink something, your body takes what it needs out of that thing you ate or drank and then it takes the others that it don't need and push it down, until it's the limit. Then it must come out, then you go to the toilet, né? So, in alcohol there's nothing that the body can take. Now, so you're destroying the health inside your stomach's insides, then it makes it *deurmekaar* [confused], *ja*, like a chaos inside your body.
>
> Matla: Alcohol also affects your liver. Like whisky …
>
> Sameerah: It's too strong …
>
> Matla: *Ja*, so whisky makes your lungs white.
>
> Sameerah: Because it's too strong. It's almost like when you use Jik [a brand of bleach] on black clothes, then the colour comes out. There's a lady here in Z Block. Her face starts to get white, then that means she has a white liver.

Gabriel: She looks like an albino …

Sameerah: *Ja*, then there's only spots of your real colour. There's white-pinkish spots. That means you have a white liver. Alcohol is too strong!

Their masterful observations on the effects of alcohol on the body (albeit not scientifically grounded) were described by Gabriel as "general knowledge." By general knowledge Gabriel meant knowledge sourced from their everyday surroundings. This point was echoed by Sameerah who said, "When you see that that person is addicted to alcohol, then you see that that person has all of those problems. You can see that person is suffering because it shows out on their face. They get those spots, their lips is always [she pulls her bottom lip out to show the raw pink inners] like this." The *seen* world ostensibly lends itself as a crucial locus for sourcing information. They were able to assess the health hazards apparent in their home from their social interactions with their environment. Matching the general knowledge of the *seen* world, Gabriel further explained that he also learnt about health and the body from school subjects such as Life Orientation and Natural Science, further solidifying observations gleaned from the repertoire of general knowledge. He said, "My week was so nice. I ended my exams on Tuesday. New people came to our school to teach us about HIV/AIDS and soccer. They come every day. I really like to be with them, because then I know how to handle HIV/AIDS when I'm big." His insight highlights the impact one's socialising environment has on the construction of health lore.

In probing further, and as a way to understand what solutions to health the children were familiar with, I asked them about their daily healing lore:

Efua: So, does anybody do any home remedies? I do lots of them!

Gabriel: *Ja* …

Efua: What are some of your home remedies?

Gabriel: I know the one with the onion and the vinegar.

Efua: What's that one?

Sameerah: To cool you down.

Gabriel: For my chest.

Efua: When you have phlegm in your chest? Or?

Matla: When you can't speak properly.

Sameerah: And you can drink ginger beer when you also have flu. They throw it in the pot and make it warm, then you drink.

Gabriel: Med-Lemon and ginger beer for a *babalaas* [hangover].

Efua: Med-Lemon and gingerbeer, like Stoney?[16]

Sameerah: *Ja*, Stoney.

Efua: Ok, so that's for a hang-over. Ok, so we were talking about onion and vinegar for your chest. Does it work?

Sameerah: Yes! The Stoney also works.

Efua: How does it work?

Sameerah: You throw the Stoney in the pot and then you let it boil and then you drink it and then it works for your flu. When you feel you are getting the flu, then you drink it and then you can cure quicker.

Efua: And then how do you make the onion and vinegar?

Laelynn: You take the onion and you put it in a bucket and mix it with sugar and water and then put it in the fridge until it becomes like a syrup kind of thing. Then every time, you just take some of the syrup.

Matla: *Naaai*! [No] It's with *suurlemoen* [lemon] and you mix it with sugar and onion.

Efua: So you grate the onion and then you mix it with vinegar. How much do you take?

Matla: You can take a teaspoon out of the glass every few hours.

> Sameerah: *Als* [*Artemesia* or wormwood])![17] You take that. And then you throw boiling water [in a cup]. Then you let it stand, until the water turns into a yellowish colour and then you drink it. It also helps you if you have high blood [pressure]. Yes, my mother drinks that when she feels that her high blood is there, then she drinks that. And when your stomach is aching, you also take this *Als* … You just pack it on your stomach. You make it warm and you just pack it on your stomach, then you put something around it.
>
> Efua: Does it help?
>
> Sameerah: Yes.
>
> Efua: Where do you get the *Als* from?
>
> Sameerah: You can grow it in your yard, but my mommy always gets it from a friend here in "I" Block. Her mother has a lot in the yard.

The children's accounts reveal the extent to which their health seeking choices are moulded by their environment and the availability of health care products and facilities. In the face of circumstances that make the maintenance of health challenging, urban dwellers turn to home remedies and familial healing pathways to secure health. These solutions reveal the creativity that is central to the children's approach to healing. The children's reflections provide an indirect cautionary message of the challenges in health care experienced by those with low socio-economic status.

In many of the children's reflections, the environment was central to the meanings they constructed and attached to their lives. The compacted, hardened earth which they depicted in their body map (see Figure 2) became a physical metaphor of the gritty experiences of life on the margins. What becomes directly visible is the experience of the children and their families in Blikkiesdorp where the barren, windswept and rough terrain becomes the landscape on which children etch meaningful reflections about their world. Their solutions to illness sourced from home-based remedies constitute a small way in which the residents of Blikkiesdorp in general reclaim a sense of agency in managing their own illnesses.

Aalif's accounts of his illnesses illustrate the centrality of housing to the illnesses he lives with:

> My mother buys my pills for me when I get sick. My chest closes and I can't breathe. I have to take an asthma pump. [Being sick] doesn't make you feel right because I have to hold my chest just to breathe. It hurts a lot. When it is storming outside here, it really affects my asthma. It gets cold at night here. My eczema gets worse because of the sand. The sand gets into the sores and makes them itch. I am not allowed to scratch because that's how I make it worse.

Aalif's ailments are common illnesses that affect people living in unhealthy housing conditions (see Burridge and Ormandy 1993).[18] The WHO states that "the accumulation of indoor pollutants and dampness … are factors in the development of allergies and asthma. Poor housing quality and design also can exacerbate the health impacts from exposure to temperature extremes" (WHO 2010). For Aalif, being ill made him feel something other than "right." Living in a poorly insulated tin structure exposed him to cold conditions that triggered his respiratory weakness and therefore was central to his health. The sandy, windy conditions of his environment aggravated his eczema. When asked if he had visited the clinic for proper diagnosis and treatment he replied, "it costs too much money for the medicines the doctors says is right." When asked what he thinks will happen to his illnesses if they go untreated as he grows older, he replied, "I don't know what will happen in my future, so I don't know what will happen with my illnesses." Offering some support on hearing his story, Sameerah shared how she had healed from eczema. She said, "When I was still small, I had eczema and so my mom would feed me bananas and then put the peel on my skin. I used to have it bad, but now you can't even see the scar that much from it." The effects of living in a tin shelter, with only a few resources at one's disposal, meant that being subjected to extreme variations of temperature and living in a dusty environment induced illnesses which forced households to call upon their personal medical lore to ease pain and nurse bodies into health.

Jafari reflected on adequate housing as "somewhere where there isn't bad things happening all the time and where we're not sick all the time because of where we stay." The most moving

stories shared by the children during the two-year research dealt with their desperate yearning to be provided with better, healthy housing. Some of these stories linger:

> Sameerah: It is not nice to live in Blikkiesdorp because when it is cold, it is not nice and also when it is hot [it is not nice]. I wish we could get houses. I want the government to give us houses. Here in Blikkiesdorp we don't even have money for bread. I am crying in my heart for a house. I am very confused because I don't know which side to go. I wish someone could help us. Give us a house, please, government. We don't want Blikkiesdorp.
>
> Gabriel: I don't feel nice to share one toilet with four houses. Here in Blikkiesdorp are a lot of blocked drains and toilets. Lots of people and children are getting sick from using the toilets that are blocked. When it is raining, all the water are laying in the streets. I don't think it is fair towards the people that are living here. Lots of people are dying here and lots of children are getting born here.

Concluding remarks

The research process sought to explore the health perspectives of six children living in a TRA on the outskirts of the city of Cape Town. What these perspectives show is the burgeoning impact systemic forms of inequality have on a growing urban population and their recourse to public health. Kim et al. (2002) echo this argument in fuller form in their edited work on global inequality and its relationship to health. What remains central to their discussion, and indeed what the stated research here has shown, is an attention to the micro-narratives embedded within the macro-economic context. But what can we make of these expressed inequalities? How can these details be tangibly applied in a global analysis of health inequalities? It seems that, at best, stories and pictures of people suffering invoke feelings of anger and sadness in critical analyses of the macro-structures that drive poverty and inequality and, at worst, relegate people's experience to the objectified margins as indicators of "othered" narratives of inequality. This paper attempts to recompose the looking glass to a finer, more nuanced incorporation of the micro-stories that survive within the macro-metanarratives.

The body-mapping exercise opened the discussion about the experience of health and illness in the body. Using their embodied experience as a reference point, the children articulated their experiences of living in and on the margins of health. Their aspirant vocalisations express the hope that someday the long-awaited, government-subsidised brick housing would be provided. For the children, better housing units, an alternative to the corrugated iron shelters, signified health, safety and stability. In finding a proper home, the everyday experience of surviving on the margins could abate. The children's aspirations for adequate housing pin the discussion directly onto a wider landscape of existing inequalities. The children's descriptions and expressions of health and illness go a long way to show that inadequate housing exacerbates illness and that strained access to the public health system compromises their quality of life. The children's micro-level experiences, reflected in the *materia medica*, their knowledge of the therapeutic properties of healing substances, are the cogs that determine what solutions are possible. Attentively listening to these stories is crucial to understanding and remedying an ever-increasing divide between urban socio-economic populations.

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Notes

1. The early promises of a newly democratic South Africa celebrated the drive for a massive overhaul in the distribution of land, capital and social services. The initial blueprint to address inequality was the Reconstruction and Development Program (RDP). The RDP was designed to create interventions to improve the standard of living for the majority of the population by providing housing (a planned 1 million

new homes in 5 years), basic services, education and health care. The RDP did retain some redistributive elements, but these were rapidly abandoned in favour of the Growth, Employment and Redistribution (GEAR) programme of 1996, which in turn was replaced by the Accelerated and Shared Growth Initiative for South Africa (ASGISA) in 2006. The objectives of the ASGISA are to address the joint crises of poverty and unemployment as this is seen to be the trigger point for continued socio-economic flaws. With a population of approximately 50 million and two-thirds of its citizenry living in urban areas, South Africa continues to grapple with the growing differences in housing quality, income and wealth.

2. The call for healthy housing was made at a WHO international workshop in Geneva held from October 13–15, 2010.
3. In this paper, "health" connotes body, mind and social experience, in relation to economic and infrastructural inequalities.
4. The children's names are pseudonyms in accordance with ethical research standards outlined in my doctoral study and larger SANPAD project of which this research is part (see Acknowledgements).
5. The ages of the research participants were recorded on October 16, 2010. They serve as an indicator to situate the children's reflections in a wider spectrum of childhood studies. Other indicators like race and gender bear little consequence given the small sample used. What is more important to signify here is the category of "child" from where an analysis of the quality of life is judged. One of the major arguments made in my doctoral thesis posits for the re-figuring of children's reflections as valuable and useful in developing sustainable public-service policies.
6. Not to be confused with the long established Centre for Creative Education (http://www.cfce.org.za/cfce/), a training centre based on the Waldorf educational philosophy.
7. I use the term *lifeworld* to mean the complex whole in which human beings imbibe and describe meaning. It is premised on a collective experience, or an ecology of knowledge systems that reflect a nuanced social and cultural experience. In a way, it joins together Husserl's expression of a collective consciousness of experiential life with Habermas' socially and culturally referent theory of how social beings interact within their worlds.
8. The N2 Gateway Housing Project is a highly ambitious housing settlement plan operationalised in 2005 by the national Department of Housing Settlement, the provincial government of the Western Cape, the Cape Town City Council and the Housing Development Agency, an independent "implementing agent playing a facilitative role" (N2 Gateway Update 2011).
9. Backyard shacks are small wooden houses or informal shelters made from scraps of corrugated iron, wood and plastic sheeting constructed by home owners in their back yards. These shacks are rented out as a source of regular income. Backyard shelters cost anything from R 400 to R 2 000 per month.
10. 12 000 units were supposed to be built as part of Phase 1. Beset by structural problems from the beginning — an adequate geotechnical assessment would have discovered much earlier that the Joe Slovo settlement was not only built on a landfill unsuitable for high-density housing but also stood on a 50-year floodplain site — only 705 units were constructed and only one resident of those evicted was relocated (Thamm 2006).
11. Many of those occupying these homes claimed to have been on the housing waiting list for years without reprieve. After a two-month, drawn-out court battle involving the backyard dwellers and key governmental operatives, those occupying Phase 2's unfinished units were evicted.
12. In 2004, the Minister of Housing, Lindiwe Sisulu, introduced the Comprehensive Plan for the Development of Sustainable Human Settlements, known as Breaking New Ground (BNG). The BNG was meant to remedy defects in previous state housing programmes, which had been characterised by corruption, mismanagement and poor workmanship. The BNG utilised the cooperative strength of national, provincial and local government in an effort to lessen bureaucratic hurdles and ensure faster delivery (Tissington 2011).
13. Oil of Wintergreen or methyl salicylate is the active compound which is similar to aspirin (acetylsalicylic acid) and, when digested, produces the same pain relieving results.
14. Grandpa headache tablets and powders have analgesic, antipyretic and anti-inflammatory properties. They are used to provide symptomatic relief for fever and mild to moderate pain, such as headaches, toothache, colds and flu.
15. Calamine lotion is either a mixture of zinc oxide and ferric oxide or is a zinc carbonate compound. It is used as an anti-pruritic (anti-itching) agent to treat conditions such as sunburn, eczema, rash, poison ivy, poison oak, chicken pox, insect bites and stings. It is also sometimes used as a mild antiseptic to prevent infections brought on by scratching the affected area, and as an astringent to dry weeping or oozing blisters and acne eruptions.
16. Med-Lemon is a cold and flu remedy. Stoney is a carbonated ginger-flavoured soda produced and packaged by Coca Cola South Africa.

17. *Artemesia* is a genus with approximately 400 species of the Asteraceae (daisies) family.
18. In their study of the conditions of health in informal housing in London, Burridge and Ormandy found that respiratory complications were the most commonly occurring illness in "slum" areas and asserted that these are "traditionally linked with bad housing" (1993, 43), mental illnesses and stress-related morbidity. Although the study is based in the broader English landscape, similarities can be made between conditions in London "slums" and the Blikkiesdorp TRA in which the children of this research lived.

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