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**Community Health Workers in Khayelitsha: Motivations and
Challenges as Providers of Care and Players within the Health
System**

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DECLARATION

I, Alison Swartz (SWRALI002), hereby declare that this is my original work and has not been presented before for the award of a Masters' Degree in Public Health.

Signed:

University of Cape Town

ABSTRACT

Community health workers (CHWs) play an important role in health care in South Africa and similar countries, but relatively little is known about CHW motivations and experiences in the provision of care. This thesis considers these issues in three parts:

1. A protocol for a study of community health work in Khayelitsha, an impoverished peri-urban settlement near Cape Town, which is home to a number of ‘flagship’ public health interventions aimed at HIV/AIDS and TB.
2. A review of literature on community health work exploring naturalistic versus economic discourses around care work, and the complex intersections of these discourses.
3. An ethnographic account of CHWs who provide a wide range of community-based care work in Khayelitsha. Carers often view care work as a natural feature of female, African or Christian identity. Care work also allows providers access to opportunities for further training, increased responsibility, and eventually, paid work of a higher status. The apparently dual construction of care work – as both natural and economically motivated – is not experienced as a contradiction. The study explores this relationship between the natural and the economic for women and men who are involved in caring practices in Khayelitsha, as well as the ways that this care work is experienced differently across the generations. Rather than being discursively produced as mutually exclusive, naturalistic arguments intersect with economic motivations linked to the relationship between love and money and a process of professionalization.

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PART A: PROJECT PROPOSAL

Community Health Workers in Khayelitsha: Motivations and Challenges as Providers of Care and Players within the Health System

INTRODUCTION

The health care systems of low and middle-income countries in sub-Saharan Africa, faced with a range of public health challenges, including the burden of high HIV prevalence, have been consistently compromised. In many cases, these health care systems have been rendered unable to meet the basic health care needs of the people (Hermann et al 2009). The crippling effect of the considerable burden of disease, coupled with severe shortages in medical equipment and supplies, human resources and general capacity, have made space for other kinds of health workers, patients and treatments. In the context of scarce resources and the complex demands of the interrelated epidemics of HIV and TB, a range of lay health care workers perform a variety of care-related tasks in impoverished areas.

In recent years in South Africa, and other sub-Saharan countries, research, support and interest in CHW programmes have increased. CHWs have been recognised both as a means to address shortages in health care professionals and a way to meet health-related care needs (Clarke et al 2008). Community health workers (CHWs) have a wide range of work titles, roles and responsibilities, and have been recognized as one strategy to address the challenge of health care worker shortages, particularly in low-income countries. In the past few decades, the valuable contribution that these workers have made to public health systems has been recognized, and enlightening research has emerged around this subject (Lehmann and Sanders 2007).

Despite of the extensive variation in roles, responsibilities and remuneration, CHWs continue to play a central role in reducing the negative effects of what has in South Africa been called the public health “human resource crisis” (Clarke et al, 2008). As Schneider and Lehmann (2010) explain, there are virtually no primary health care clinics in South Africa without lay health workers linked to them, working either at the facility, or providing home-based care in

the area where the facility is located. The struggle for appropriate, accessible and adequate forms of health care is of continuing concern, particularly in informal settlements, where access to basic health care and other services, including water, sanitation, and adequate housing, is severely compromised.

Khayelitsha, one such settlement outside Cape Town, has become the focus of much international, donor-driven attention, partly as a result of its high HIV and TB prevalence. CHWs, as individual community members, or working through community-based organisations (eg. NGOs and faith-based organisations) perform a vast array of care-related tasks, many of which provide support to people living with HIV/AIDS or suffering from TB. CHWs provide practical services, for example washing chronically ill patients, and also offer education about different illnesses: infectious and non-communicable, acute and chronic. Although there is research highlighting the role and activities performed by CHWs, little is known about CHWs' motivations for doing the work they do, or understanding of their positions within the health system within a broader, more formal public health system in South Africa.

In order to more fully understand the role the CHWs play, we need to explore CHWs' experiences and perspectives of, as well as motivations for providing the care that they do, in the context of considerable economic marginalisation, where their financial remuneration is not always guaranteed. This research could be used to supplement understandings of how CHWs see their role within their communities and the health system more broadly. It could also contribute to efforts made to better implement and utilize programs run by CHWs in the context of South Africa.

Rationale

In an exploratory study of CHWs in Khayelitsha conducted recently (Schneider et al, 2010, unpublished), it was found that CHWs are linked to 56 different health-related non-governmental organizations (NGOs). Some of these organizations are large, well-run internationally and partially government funded while other organizations consist of but a few women performing ad-hoc, informal caring roles. Perhaps part of why there has been such a significant interest in Khayelitsha was that it was the initial "pilot site" for the provision of the first ARV program in South Africa (Levy, Miksad and Fein 2005). The

contributions and work of this multitude of different health-related organizations have meant that the CHWs working there tend to have quite varied roles, responsibilities and places of work, thus making Khayelitsha an interesting context in which to interact with CHWs.

Town Two has been chosen as the specific site within Khayelitsha because although it has been impacted by the range of large external public health or care organizations, it is not, unlike Site B, the epicenter of such large, external organizations (for example TAC). As a result, CHWs working in Town Two may have different experiences to those working in areas of Khayelitsha like Site B but would still have been impacted by close proximity of these external organizations. Town Two is therefore an interesting space to base this research as it should allow us to investigate the impact of external actors on the CHW, as well as the ways that it may be provided in Town Two itself.

Another rationale for choosing to do this particular research is that there has been an important shift in the nature of care for HIV-positive individuals. As mentioned above, CHWs play an important role in caring for people living with HIV and TB. Prior to the national roll-out and sustained provision of ARVs, CHWs may have needed to care for people who were more acutely, or episodically ill. Now, however, people living with HIV are more likely to need care that helps them to manage HIV as a chronic illness. As peoples' care needs have changed and shifted, CHWs responses would also need to have shifted in particular ways. Little research has been done into this shift, and how CHWs motivations and experiences may have been affected by it.

Currently the policy on CHWs is fragmented and obscures the nuances of the situations in which such care work is received. Instead of having one coherent policy framework, there are ad-hoc, uncoordinated, program-specific policies. In anticipation of the formulation of one such policy, Clarke et al (2008) wrote about the complexities and barriers involved in such a process. This policy has not yet been finalized, and as it stands, CHWs are not governmentally formalized, but are instead regulated in the local contexts in which they work. In order to better inform the development of policy and programming at the national level related to CHWs, there is a need to understand CHW motivations. An understanding of CHW motivations is particularly important in light of the fact that many work for little if any financial remuneration, and there is high turnover, which could threaten the effectiveness and sustainability of CHWs as a solution to the considerable "human resources for health" problem (WHO 2008).

The existing literature on CHWs in South Africa highlights the fact that CHWs play and have the potential to play a crucial role in the provision of health services and support to people living in South Africa. But using CHWs as a solution to the human resource crisis without having an understanding of their motivations could lead to further policy and programming blind spots and challenges. The purpose of this study is to elucidate motivations and perceptions of CHW as providers of care, and as players within a broader health system. As there is little existing literature on the subject in South Africa, this study represents an important area of research. The findings of this research could help to inform the much-debated South African national CHW policy, as well as other public health policies that concern CHWs in other ways.

RESEARCH QUESTIONS

Main research question:

What are CHW motivations for and experiences of providing care in the context of extreme economic scarcity?

Subsidiary research questions:

- What motivates CHWs to initially start doing community health work?
- What are some of the challenges of providing community health work?
- What are the benefits (both personal and beyond) of providing community health work?
- What are CHW perceptions of how the community see them, the care they provide and their roles within the health system?
- How are CHWs remunerated (financially or otherwise) for the services they provide?
- How do CHWs view the work of other people in the community providing similar care?

METHODS

Population and Sampling

The primary population and field site for this ethnographic study will be the residents and area of Town Two in Khayelitsha. Khayelitsha is the second largest peri-urban settlement in South Africa where between 800 000 and one million people are said to live (MSF 2009). Khayelitsha is a sprawling space characterized by varied but often poor access to services, including water, sanitation and electricity. The inhabitants of Khayelitsha often struggle to gain adequate access to health care services in the areas that they live. Khayelitsha has been divided up into smaller sections; Town Two being one such sub-section. Initial access has already been negotiated through Monwabisi Maqogi, who lives in Town Two. He runs a church in the area, as well as support groups for men and women living with HIV/AIDS.

It is important to recognize the ways that my research, and the research process, is shaped through my working closely with Monwabisi (Monwa) Maqogi, who acts as both as a key informant, but also as a kind of “gatekeeper”. Monwa introduced me to many people in Khayelitsha and his presence during many of the conversations I have had has undoubtedly affected the ways that people have interacted with me in the field. In my experience of having known Monwa for some years, I have always found him to be open about his perceptions of people I have been interested in meeting. Although this may be the case, I cannot discount the fact that for the most part, the people with whom I spent a significant amount of time were held in high esteem by Monwa himself. As a result, if he were to be present during my conversations with people he knew, or had introduced me to, I would think that those individuals may feel more comfortable to speak to me. Although the contents of our conversations were not often of a typically sensitive nature, I could not be sure if Monwa’s presence made people feel less able to speak openly about particular subjects.

Some of the likely people who would be participants in this research include CHWs themselves, patients who have contact with CHWs, organizers of CHW programmes, and people who work in any organizations related to health, or “social care”. Some of these organizations include TAC, MSF, Khayelitsha Site B Clinic, the women who run soup kitchens in Khayelitsha, and the people who have started support groups and vegetable gardens in order to care for the sick, elderly or children in the area.

When conducting long-term ethnographic research, people of places outside of the primary field site and population of Town Two may be of interest. Some of these “secondary” interest groups may be people who work for MSF or TAC, Shawco volunteers, and any other people or NGOs, CBOs (community-based organisations) and other aid and activist organisations with which the primary population from Town Two engage. As with qualitative ethnographic research more generally, decisions to pursue interviews or other forms of data collection with members of these populations will be guided by the research questions and observations emerging from work with the primary population over the course of the project.

Data Collection Methods

The purpose of this study is to elucidate motivations and perceptions of CHW as providers of care, and as players within a broader health system. In order to capture the perceptions, thoughts, feelings, opinions and interpretations from multiple participants and sources, the study will be ethnographic.

When conducting ethnographic research, one can allow what is learned in the field to dictate the direction of the research. As an ethnographic researcher based in Town Two, Khayelitsha, I will spend an extended period of time with informants engaging in whatever activities in which they engage. Participant observation will therefore be my primary data collection method. The extended time period I will spend with participants may allow them to feel more comfortable to share details about their situations, thoughts and feelings and would facilitate participants’ feeling more at ease with my presence more generally. In this sense ethnographic research design has some similar benefits to a longitudinal study design. As research is conducted over an extended time frame, greater validity and reliability could be ensured. During my time in the field, I will be paying close attention to everything I see, hear and am told, which should help me to gain deeper insights into the context and specific situations in which community health workers live and work. These kinds of insights may be impossible to gain using any other research design and will also, usefully, dictate how and where the research will take shape. Decisions to pursue different avenues of inquiry or to include different study populations would be guided by the research questions and observations that would emerge during the research period.

The most important instrument for data collection in long-term ethnographic research is “participant-observation”. As stated above, the primary form of participant observation I would engage in would be to spend time with informants doing what they would do during their days. At times this may mean walking around their neighbourhoods with home-based carers, cooking soup with women working in soup kitchens, or watching over children in small care organizations. Through becoming immersed in the daily lives of my informants, I hope to occupy the privileged position of being both an insider, participating in particular activities myself, and an outsider, undertaking more distanced observation. Although this method may for some raise concerns around objectivity, reliability and generalisability, it is increasingly being used in other disciplines, often in conjunction with and as a means to supplement other methods. My use of participant observation will offer me the opportunity to gain detailed, nuanced insight into the lived day-to-day experiences, practices, feelings, thoughts, and interactions of a group of people.

In addition to participant observation, several other qualitative research instruments will be used. A series of semi-structured, topic-driven interviews, exploring perceptions of CHWs as providers of care and as players within the broader health system, will be conducted with CHWs and community members in Khayelitsha. Other groups or key informants with whom focus groups or interviews might prove useful would be identified in the course of the research period. Document reviews of any materials related to CHWs in any way would also be reviewed, and may form the basis of some other, more specific questions to participants.

The kinds of data collected will include fieldnotes (researchers’ observations and insights), interview and focus groups summaries and transcripts, survey responses, and documents. Issues of anonymity and confidentiality are discussed in the ethics section below.

Analysis Approaches

In this study, a range of methods of data analysis will be undertaken. The first is “thematic analysis”, which involves the identification of key themes for analysis. I would anticipate key emergent themes being related to both the positive and potentially challenging aspects of being engaged with community health work. This thematic analysis would drive the analysis process, and inform potential secondary forms of data analysis. The second analysis approach, which is important as the study seeks to explore perceptions of the relationship between CHWs, community members and the health system, is “social network analysis”.

This analysis looks at the social networks and relationships that people have created and what they accomplish. Where it is relevant and possible, “narrative analysis”, which concerns the ways that human experiences are understood and expressed through stories, as well as “discourse analysis”, which is the detailed study of language and the ways it encodes ideological values and relationships of power, will also be undertaken. Narrative analysis may be helpful in analyzing lengthier conversations or interviews. Discourse analysis may be useful in analyzing the ways that community health workers may speak about each other, or other key role players in the health system.

The combination of these forms of analysis will be combined into a nuanced ethnographic interpretation of CHW motivation in this context.

RELIABILITY AND VALIDITY

Reliability and validity in qualitative research can be strengthened in a number of ways. The use of multiple sources and kinds of data to confirm the analysis of a particular phenomenon, or “triangulation”, is one of the most common techniques used to increase validity and reliability. Qualitative research, as it uses a wide range of data collection instruments, including interviews, observations, informal conversations, document reviews, and survey results, offers ample sources of information with which to triangulate.

Another important way of strengthening validity and reliability in qualitative research, particularly research that aims to explore local perceptions and experiences, is to involve participants and researchers in a process of mutual feedback during the study period. Researchers should offer regular feedback of the findings of the research to participants and ask for their comment. This process is often called “member-checking”. It allows researchers and community members to correct, refine, and/or add to the study’s content and design. By involving study participants in the study design, data collection and analysis as much as possible, important themes can be identified early, potential barriers to successful data collection can be avoided, interpretations can be reworked and refined on an ongoing basis, and study participants often offer fuller and more candid responses to interview and survey questions. Regular feedback offers an important opportunity during research to test and improve understandings of research context and preliminary findings.

KEY ETHICAL CONSIDERATIONS

Researchers should always conduct *themselves* ethically in the research context, but in the context of Khayelitsha, where people live in economically trying situations, I recognize the need to be particularly aware of and sensitive to my relative socioeconomic privilege. In addition being cognizant of my own privileges, I will also consider a range of other ethical issues. CHWs, as community members of Khayelitsha and as providers of care, are likely to have witnessed and personally experienced social, physical and economic challenges related to their work or provision of care. Some of these challenges may be emotionally distressing to talk about. The possibility of CHWs experiencing emotional distress would be discussed with key informants before the study would be conducted. These informants would be shown lists of semi-structured interview questions as well as the surveys so that they could comment on the appropriateness of their content. In addition to prior discussions with key informants, I would also allow participants to direct conversations themselves, thereby avoiding asking more difficult questions.

Another point to consider is access to peoples' private homes or organizations. Monwabisi Maqogi, as the pastor of a church in Khayelitsha, is a prominent and respected community member, and as he will be closely involved with all initial fieldwork, entering these spaces should not be difficult or uncomfortable. However, sensitivity to the power relations that exist between researchers and participants will be kept in mind at all times, and where access to these spaces appears to be granted reluctantly, discretion will be used and research moved elsewhere.

Although there are no direct benefits for research participants, the research outputs could be valuable to a number of individuals and organizations. This research could inform the ways in which future CHW programmes are managed and run, and in this sense, health systems, including doctors and people in managerial positions at hospitals or clinics benefit from it. Also, as the policy for CHWs is being formalized, this research could inform this process further. Health systems as well as care related or activist organizations (NGOs or CBOs) can use this research to better understand the experiences of patients and CHW from a grassroots level in order to ensure that the work they do is best tailored to the populations they work with/for. This research will also be beneficial to members of the public who are interested in understanding the nature of social care in impoverished areas from a grassroots perspective.

Compensation for participation in the research will be offered. As the nature of the research requires long-term, sustained involvement with the participants, I will assist in whatever projects or activities participants are currently engaged in. Negotiating compensation is often tricky, as one does not want to be seen by participants as someone able to offer a limitless source of financial or other similar resources. Instead, I will offer their time, and skills, and in this way, compensation will remain sustainable. I may also seek financial or other resources from outside sources in order to fund projects being undertaken by the participants. I will use my own discretion to ensure that such funding is also sustainable (if it is required to be). Copies of all photographs, audio recordings, transcripts and written products produced during and after the research will also be given to participants. Refreshments will be served during lengthier semi-structured interviews, should it be necessary (for example, if interviews continue through lunch time).

Verbal informed consent will be secured from individuals who partake in interviews and focus groups as well as from participants with whom researchers have had and wish to record informal conversations. The UCT Health Science Faculty's guidelines on verbal consent will be used in order to adequately and sensitively obtain informed consent. Anonymity in data collection, analysis and write-up will be secured through the use of pseudonyms and the removal of identifying information from records. Confidentiality will be ensured by making the collected data available only to me as the main researcher, my supervisor, Dr Chris Colvin and research participants themselves, where appropriate.

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PART B: LITERATURE REVIEW

Community Health Workers and Discourses around the Provision of Care

INTRODUCTION

Community health workers (CHWs) play a valuable role within the South African health system (Schneider and Lehmann 2010). Research about CHWs has the potential to contribute to health systems strengthening by affording a better understanding of CHW roles, responsibilities and experiences. This research explores the experiences and motivations of community health workers in the impoverished context of Khayelitsha, South Africa.

Fieldwork in this site uncovered compelling and competing discourses for why and how people find themselves involved in community health work in Khayelitsha. Broadly speaking, these discourses fall into two main categories: the naturalistic and the economic. The 3 naturalising discourses for CHWs are centred on gender, race and religion. The first of the two economic discourses relates to the relationship and tensions between the gift and the commodity, or love and money. The second economic discourse relates to the process of CHW professionalization, or attempts to develop a career path within the care work arena.

In this literature review, I begin by placing CHW in the context of the South African health system. I then explore literature on naturalizing discourses related to care work as well as literature that addresses economic discourses linked to care work. Finally, I highlight the ways that the literature about CHWs has contributed to the relative invisibility of their experiences and motivations.

Community Health Workers in South Africa

The shortage and maldistribution of health care workers continues to perpetuate global health challenges (Chen et al 2004; WHO 2008). In low and middle-income countries, the contribution of “lay” or semi-professional health workers to the response to these health challenges has been recognized (Callaghan 2010). By shifting less specialized tasks from

doctors to nurses, midwives or lay health workers, the hope is that the human resources available in even the most compromised health systems may be optimized. The complex cadre of lay health workers has been documented to provide people with support, assistance and treatment for a wide range of diseases and conditions (Lewin et al 2010). Some of these workers make home visits or cook for patients in impoverished contexts, offer support to health workers in health intervention strategies, and run support groups or other community-based projects that seek to address a range of health conditions. (Schneider et al 2010 unpublished). The care work in which CHWs engage is generally home-based, low-skilled and fairly intimate. Lay health worker roles, responsibilities and levels of training and supervision vary greatly both across and within different country contexts (Lewin et al 2010). In these different contexts, those performing a range of tasks have been given many different work titles, including lay health workers, health volunteers, home-based carers and community health workers.

Despite the variation in naming, roles and responsibilities, this cadre of workers has been recognized, and utilized to address what has been called a human resources for health “crisis”, which has, in recent times, been extensively documented (WHO/PEPFAR/UNAIDS 2008 and Chen et al 2004). Community or lay health workers’ involvement in addressing the considerable burdens of both HIV and TB pandemics that continue to fundamentally shape and ultimately compromise the health systems of low and middle income countries has been also increasingly documented (Callaghan et al 2010). And yet, the experiences and motivations of CHWs have remained largely invisible both globally, and in South Africa.

In South Africa, several factors have contributed to the invisibility of CHW experience and motivation. Although CHWs have been working in South Africa for over a hundred years, these workers were not originally recognized by the post-apartheid Department of Health (van Ginneken et al 2010). CHWs were not, at the advent of South Africa’s democracy in 1994, included in the formalized National Health Plan (ANC 1994). Instead, funding from both national and international sources that previously had been used to employ CHWs was diverted into government-run health care initiatives (van Ginneken et al 2010). The failure of the government to formally recognize CHWs meant they were left without jobs or a guaranteed source of income. In the newly democratic South Africa, the 1996 Constitution turned the hopes of better living conditions and employment opportunities into legally enshrined, though progressively realised rights.

Perhaps the racist legacy of the apartheid government system contributed to the initial lack of formal governmental recognition of the community health worker role. It was only in 2004, a full ten years after the advent of democracy, that a CHW policy framework was established and adopted, with the hope of, amongst other things, financially rewarding CHWs for their labour. Although the creation and adoption of this CHW policy framework can be seen as a step in the right direction, it problematically made no stipulations about providing these workers with a salary, but instead a small stipend (Schneider et al 2008).

It is clear that although the contribution of CHWs to the health system is partially recognized (Schneider et al 2008; Schneider and Lehman 2010) they remain precariously positioned in South Africa. In part as a result of the lack of governmental support for community health work, various discourses have emerged from CHW themselves in an attempt to make sense of their own roles and motivations as care workers.

Naturalizing Discourses around Care Work

There are several discourses within the literature about both care and community health work that argue for a set of innate or “natural” attributes that have been historically linked to the provision of care. In the section below, I explore how gender, race and religion act as naturalizing discourses surrounding care work. It is these naturalizing discourses that are often understood to be motivated by “love” (England 2005).

An extensive body of literature exists about the intersections and interactions between gender and care work. Gender theorists and feminist scholars have long explored the relationships between paid/unpaid labour or productive/reproductive labour, gender inequality and the “double burden of care” (Budlender 2011 and Hervey 1998). What is perhaps most interesting in the literature about gender and care work, is the way that both gender and race feed into a discourse about the nature and value, both economic and otherwise, of the kinds of work in which CHWs engage.

England (2005) and Himmelweit (1999) explain that gender, as well as race, contribute to the devaluation of care work. For decades, paid caring labour, including occupations like nursing, occupational therapy, psychology and so forth, have been performed by white women with

university degrees. Other kinds of care are provided by women who are not white or who are immigrants (England 2005). Women, and more specifically black women, have been seen as having a complex moral obligation to care (Tronto 1994). The imagined “black woman” as a mother, a care-giver and a nurturer, has also been imagined to be “naturally” inclined towards the provision of community care. Perhaps perceptions about “natural inclinations” towards care have contributed to the perpetuation of poor remuneration for this nature of caring work.

These discourses are not only racialised but also located within essentialised cultural notions of African identity. The response to health-related challenges in South Africa, including the HIV and TB epidemics, have, for example, been described in terms of *ubuntu*, or a uniquely African ethic of care (Manda 2007). Scholars who have explored care in African (impoverished) contexts have in part explained peoples’ roles as carers, for family and community members, through their sharing a sense of *ubuntu* with those around them. This discourse has in part been used to explain peoples’ continued commitment to community care, despite a lack of economic benefit.

In addition to race and “African-ness” or *ubuntu*, religion, or faith is another naturalizing discourse in care work. The contributions, collaborations and motivations of faith-based organisations (FBOs) in the field of health have been explored extensively (Kegler et al 2010; Goldman and Roberson 2004). It has been documented that multiple local governmental health departments collaborate with varying numbers of FBOs, in a range of different ways (Barnes and Curtis 2009). Part of what has been described in the literature about the facilitators of these collaborations is linked to FBOs’ “passion and commitment” (Kegler et al 2010: 669) to addressing health disparities in local communities. In this way we see the ways that peoples’ motivations to care for the health of their communities could be linked to their involvement in faith-based organisations.

What is important to recognize in relation to the naturalizing discourses of gender, race and religion around care is that carers’ imagined “natural” attributes shape the relationships that they have with those they care for, as well as the relationships that they form with other carers. As Himmelweit (1999) explains, it matters who the person providing the care is, just as it matters who is being cared for, and how care is provided and experienced. The carer/caree relationship is defined by motivations for caring which are assigned by gender and social norms, the development of relationships between a carer and caree, and the

expressions of dependence, reciprocity and friendship. Waerness (1984) also explores the importance of the carers' personal knowledge and experience and the ways that this contributes to the development of relationships between those providing and those receiving care.

If a monetary exchange is introduced into this caring relationship, there exists the fear that it could potentially be transformed and undermined in some way (Himmelweit 1999 and Held 2002). However, Ungerson (1990) argues there is no reason to think that personal attachments cannot develop in market relationships. Instead, personal attachments and strong feelings are a central part of caring relationships, whether the care is paid or unpaid. Although this may be the case empirically, the pervasiveness of naturalizing discourses around care work may still mean that care work could still be economically undervalued. This financial undervaluation is most evident when looking at the ways that women have been paid for their caring labour. Instead of being fully financially recognized, women tend to be assumed to have a natural inclination towards care that often stems from their being defined through their relationships to other people (often men), as wives, daughters and mothers (Nelson 1999). It is clear that the interactions between naturalizing discourses of care work and money, or more economic discourses are complex. In the section that follows I explore these interactions more closely.

Economic Discourses around Care Work

As explained above, many express a tension between the domains of "love" and "money" in the context of care work. This conflict could be framed more broadly through the concepts of the gift and the commodity (Nelson 1999). Here, the gift of love or care could be understood to build relationships, while in contrast, commodified acts of care could be seen as impersonal, alienable and exchanged in the absence of social relationship. Paid care work is uncomfortably situated between these ideas of the gift and commodity. In the section that follows, I investigate theoretical explanations for why a tension between the gift and commodity exists, and how care work in particular fits into this relationship.

When looking at the naturalized discourses around care work, there exists a problematic assumption that people vary in the amounts or capacity that they have to care, while their

costs, or economic needs remain constant (Nelson 1999). This assumption again highlights the highly symbolic divide between love and money, or between the gift and the commodity.

The central question of Nelson's article "Of markets and martyrs: Is it ok to pay well for care?" (1999), for example, concerns the issue of whether extrinsic or monetary reward lead to a reduction of love or intrinsic motivation to provide care work. She asks whether it is appropriate to pay for caring work, and if so, how much? Both Folbre (1996) and Frey (1997) point to the complicated ways that extrinsic or monetary motivations could potentially force caring or affective relations into financially incentivized obligations. In the context of South Africa, where there is a need for people to perform a range of care-related tasks in order to maintain the health of the population, it is hardly surprising that the intersections between the nature of care and money come into sharp relief.

Community health work, and how it is perceived in terms of intrinsic (love) or extrinsic (money) reward, needs to be investigated within its context. The context could be at a micro or family scale, at a community scale, or at a macro or country scale. Public health challenges in particular countries, for example, in those in the global north versus those in the global south, are significantly shaped by the countries' economic situation, and measures of inequality within countries. In South Africa, where the measures of inequality are among the highest in the world, and majority of the population lives in poverty and without employment, care has taken on a range of interesting forms. These forms including care provided through volunteerism, or the participation in faith-based (Akintola 2010), non-governmental or governmental organizations.

The South African government's provision of stipends to the governmentally employed CHWs is also an important part of this conversation. Nelson (1999) and Ungerson (1995) explore the ways in which extrinsic motivations could be thought to diminish intrinsic motivations in the provision of care. However, by acknowledging those who provide care work, for example, through honoraria or stipends, intrinsic motivation may be increased. Ungerson (1995) writes about concepts like "honorarium", where volunteers receive symbolic payments to reinforce offering care for love rather than for money. Those receiving stipends would not be in danger of being seen as profiting off the care needs of others but would instead be seen as gaining rewards linked to trust, respect and appreciation by the communities in which they work. By failing to make this kind of care work economically

attractive, it can be implicitly ensured that those who become involved in care work are doing it out of “love” or altruism.

Yet, stipends act as markers distinguishing paid or formal care from unpaid, informal care. This distinction is particularly complex in places where economic scarcity means that even when care may be understood as “formal”, and as “work”, there may not be adequate funds to remunerate it (Schneider 2008). There are also many cases where the payment of care workers reduces client or patient anxiety around the tasks that the carers are performing, as the payment of carers allows some of the burden of caring for people to be shifted away from family members (Himmelweit 1999). In addition, recipients of care from paid carers may feel more comfortable to ask or expect carers to engage in particularly intimate tasks if they know that the carers are being financially recognized for their labour.

As explored earlier, there exists a problematic assumption that women engage in poorly remunerated care work because of their innate and genuine concern or capacity to be “more caring”. As Folbre and Weisskopf (1998) explain, this makes women particularly vulnerable to exploitation. In addition, although some may begin careers in care work thinking that there may be scope for career development, this kind of career development is usually not possible (Himmelweit 1999). The danger in this situation is that women’s work as carers becomes a form of self-exploitation and undervaluation. This self exploitation is reinforced by concerns over the potential of money to corrupt caring relationships. The potential for market-related, self-interested exchanges between carer and caree to corrode affection and lean towards obligation within the relationship has also been explored (Folbre 1996). The fear of monetary or extrinsic motivations “crowding out” the intrinsic motivations for care has also been explored (Frey 1997).

Zelizer (1995) offers another useful dimension for exploring economic or extrinsic rewards in the sphere of care work. The author elucidates the social meaning of money, and the ways that money creates relationships within the market. Zelizer (1995) views the market as a complex network of rich social relationships, in which money *moves between* rather than being *paid to* people. Therefore, instead of being an “alien” exchange of funds between people, the movement of money for care work creates relationships that could have caring and loving elements to them. Here we see that even when things are being paid for in a seemingly

commodified exchange, the lines between love and money, and the gift and the commodity are highly blurred.

Radin (1996), like Nelson (1999) and Zelizer (1995), rejects the dichotomy between love and money and argues that care can be partially commodified. Genuine care always resists complete commodification, and by understanding care as being incompletely commodified, it is possible to see that care and paid labour are not two opposite extremes. These writers also reject the dualistic treatment of motivation (caring feelings) versus activity (caring acts). They reject this dualism as it places too much emphasis on the capacity for choice. In impoverished contexts, where employment opportunities are few, this would be a particularly important rejection to make.

Much of what has been extensively debated in the literature, in terms of the relationships between intrinsic and extrinsic reward, has been written in the first world rather than in the impoverished South African context. While there exists a tension between love and money, or the gift and commodity everywhere in the world, this tension is under particular pressure in the context of economic scarcity. In addition, in situations of economic deprivation, choice and motivations are shaped in particular ways. In other words, choice about whether or not one “wants” to engage in some kind of care work, or whether one is providing care “for the money” are complicated in situations of economic deprivation. As England (2005) explains, part of the way that low pay for care work is justified is through the perceived “intrinsic fulfilment” of doing care work that is perceived to make up for the low pay. The argument is that if those providing poorly paid care work were not getting some kind of other rewards for the work that they were doing, they would simply find other employment opportunities. But, in the context of extreme deprivation, this is often impossible. It is precisely because resources are scarce that judgements about peoples’ legitimacy as carers, and motivations for engaging in care work, are scrutinized. Perceptions of “profiting off of” others’ care work needs only become relevant when meagre resources need to be distributed amongst many people.

Care work and the space that it occupies in the relationship between the gift and commodity, can only be understood through exploring a range of naturalizing and economic discourses. These discourses interact in a range of interesting ways. When looking at the care work of CHWs in South Africa, it is important to explore what they do and experience within the

contexts in which they find themselves. Research on CHWs working in South Africa, where economic resources are scarce, and naturalised discourses around care work have contributed to their relative invisibility, have not thus far been centred on CHWs motivations and experiences. In the section that follows, I explore the ways that CHW motivations and experiences have been absent or partially obscured by public health literature.

Invisibility of CHW Motivation And Experience from a Public Health Perspective

Although it is largely accepted that CHWs play a valuable role in the provision of care in impoverished contexts (Schneider, Hlophe and van Rensburg 2008), little attention has been paid to the significant variation in CHW experiences. Instead, from a health systems perspective, CHWs in South Africa have been simply recognized as “bridging the gap” between the community and the health system (Schneider et al 2008). The increasing reliance on CHWs as a *vehicle* to provide health-related services is partially due to the crisis in human resources for health service delivery that has been experienced in low and middle-income countries (van Ginneken, Lewin and Berridge 2010; WHO 2008). Through the eyes of public health specialists and scholars, CHWs have been largely represented as a homogenous group of workers to which the burden of “task-shifting” (WHO 2008) has been steered. Research about CHW has tended to focus either on “task shifting”, or on the roles that CHWs play in relation to particular programmes, many of which are centred around HIV and TB treatment (Schneider and Lehmann 2010; Hermann et al 2009, Barker et al 2002 and Schneider et al 2008).

Ramirez-Valle (1998) writes about how CHWs, as women, and more specifically, as third-world women, have been “created” and “produced” by public health writings and other scholarly literature. In this sense, writings about the role of CHWs within the health system perpetuate a particular vision and understanding of “who” these women are, and the roles that they play in the provision of care. Less research focuses on how CHWs see themselves and the work that they do, or how they see themselves in relation to other CHWs performing similar tasks. This is certainly evident in some of the national literature about community health work, but also in the international literature that is primarily focused on the role the CHWs can play in terms of relieving the human resources burden within the strained public health system in South Africa (Friedman 1995; Lehmann, Friedman and Sanders 2004; WHO 2008).

As explained above, for both naturalizing and economic discourses contribute to the poor remuneration of care work. However, much of the public health literature about CHWs documents the barriers and enablers, strengths and weaknesses, lessons and opportunities related to specific CHW programmes. Although several authors call for things like “better communication” (Simon et al 2009) or increased support, training and collaboration (Lehmann and Sanders 2007 and Hermann et al 2009), the opinions and motivations of CHWs are not always included. Instead, the focus of such literature is generally centred on ways to more effectively implement, institutionalize and mainstream CHW programmes by engaging a number of stakeholders, including national health departments or related ministries, NGOs, public and private health care facilities and various other health care professionals.

It is with these blind spots in mind that I will explore in the report below the complicated ways that naturalizing and economic arguments linked to the motivation for the provision of care come together to shape the motivations of CHWs. In this way, I explore both the narratives about CHW self perception but also how these discourses emerge in narratives about the legitimacy, motivation and positions of other CHWs.

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**“It’s in Our Veins”: Gendered Natures and Caring Motivations
in a Peri-Urban Settlement in South Africa**

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Khayelitsha, an impoverished peri-urban settlement near Cape Town, is home to a number of ‘flagship’ public health interventions aimed at HIV/AIDS and TB. Alongside these high-profile, foreign donor-driven treatment and care programs are a plethora of NGOs and CBOs that provide a wide range of community-based care work. Some of these organizations are large, well-funded and well-connected globally, while others are run by a few unemployed women responding to care needs in their neighbourhoods. Community health workers (CHWs) who work for or run these organizations recount personal narratives for why and how they engage in the work that do

Carers often view care work as a natural feature of female, African or Christian identity. Care work also allows providers access to opportunities for further training, increased responsibility, and eventually, paid work of a higher status. The apparently dual construction of care work – as both natural and economically motivated – is not experienced as a contradiction. This paper explores this relationship between the natural and the economic for women and men who are involved in caring practices in Khayelitsha, as well as the ways that this care work is experienced differently across the generations. Using ethnographic data and “narratives of care”, I explore how naturalistic arguments intersect with economic motivations linked to the relationship between love and money and a process of professionalization.

Introduction

Mzi and another woman are sitting in the garage at Mzi's house, the room she uses as a base for her small organisation. *Ichibi Single Mothers* provides a range of services to people living in Khayelitsha, including home-based care, psychosocial support and treatment assistance and advice for HIV, TB and common chronic conditions. Through the doorway at the back of the room, two other women lean over large pots of food to fill the row of Tupperwares that lines the floor against the far wall. The Tupperwares belong to women living in the area who receive a small amount of food from Mzi's organisation twice or three times a week. I am sitting on the sunken couch opposite Mzi and the other woman. "I've got this problem. I need a wheelchair." Mzi says to me. She has her hand on the woman's knee. She tells me the story of the woman's brother-in-law who had a stroke and now needs the wheelchair. When he met Mzi, they discovered that they are from the same village, Chala, in the Eastern Cape and that they come from the same clan. He felt it was a "sign" that he had been put in touch with Mzi because they are "family". Currently, the woman's brother-in-law and another man who Mzi supports through her organisation are sharing one wheelchair. He was sure that Mzi could help him to find a wheelchair and I was being gently pulled into her network of caring. Working in this context, I have learned that relationships of care are flexible, expansive and improvisational.

In impoverished Khayelitsha, a peri-urban settlement on the outskirts of Cape Town, caring for a member of one's family, however this is determined, is not always an easy task. "*Ubuntu*¹ is gone" Mzi tells me. *Ubuntu* is the term used to describe a Southern African notion of shared humanity, reciprocity and a shared ethic of care (Manda 2007; Louw 2001 and Mokgoro 1998). In the past, I have heard many people say that *ubuntu* is gone, and for the most part, those who say it are older women who believe that the younger generation simply does not care enough about "where they come from", or about who their family is to participate in what could be considered *ubuntu*. Instead the youth are described as wanting to selfishly better their own lives, rather than respecting and nurturing other familial and community relationships; choices that would be in line with the central tenets of *ubuntu* (Mokogoro 1998).

¹ The concept of *ubuntu* is controversial and contested within the social science literature. I did not raise the issue of *ubuntu* with participants; they spontaneously drew on this concept in conversation in order to discuss their ideas about African-ness and caring networks.

But Mzi's notion of why *ubuntu* is gone is quite different. She told me *ubuntu* is gone because people literally do not have anything to give one another anymore. In Khayelitsha, *ubuntu* is often spoken about in relation to the Eastern Cape from where many Khayelitsha residents have migrated. Many people living in Khayelitsha still refer to the Eastern Cape as "home" (see Cassidy 2010, unpublished). Another home-based carer at the local clinic explained that whenever anyone goes to the Eastern Cape, they take "provisions" for their families and neighbours along with them. While in the past, she said people used to be able to take more expensive items like chickens or meat, now "people can only afford to give a cool-drink, if anything".

It is in this context of severe economic deprivation that I began doing fieldwork exploring various networks, understandings and practices of care. I repeatedly asked why and how people came to be community health workers (CHWs) or started small, home-based care organisations, even when they were offered little, if any remuneration for their time. The answers and justifications I was offered constitute the data for this article.

Here, as in other impoverished contexts, discourses on care take on multiple ambiguous, contradictory and sometimes overlapping forms. Broadly speaking, justifications for why people find themselves performing care fall into two main categories. The first concerns the "naturalness" of caring, linked to naturalised concepts of gender, African identity and Christianity. The second set of discourses is linked to a more economic dimension of engaging in care work, discourses that address the tension between "love and money", or between care as a gift or a commodity (Nelson 1999). For CHWs in Khayelitsha the discourses that frame their motivations and experiences of care work are also expressed unevenly across the generations.

The complex interactions between care, and how it is remunerated, monetarily or otherwise, are of central interest here. I argue that in Khayelitsha, peoples' naturalising discourses about care help to mediate the tensions in the context of economic scarcity around care as a form of paid labour. In relation to CHWs, I explore the care they provide as a simultaneous gift and commodity in the ways CHWs view their own care work, and in the ways CHWs view the care of others in similar caring roles. In this regard, the "gift" of care is freely given, in the context of relationships premised on love, or caring feelings (Nelson 1999). The "commodity", on the other hand, is something that is given only in exchange for something

else, often money, in alienation of relationships or feelings. I argue that care and caring work, like the tasks, activities and emotions associated with engagement in community health work in Khayelitsha are coded simultaneously as gifts and as commodities.

The ethnographic data in this article was collected over a period of about a year between 2010 and 2011, when I spent time with those connected to a range of different care work organisations. Monwabisi Maqogi² (known to me as Monwa), a local pastor, community activist became a key informant in Khayelitsha. Monwa often accompanied me during my visits to Khayelitsha, introduced me to many people, including Mzi, and answered, explained and clarified things that I did not fully understand. I found it both easy and very helpful working with Monwa who never withheld what he thought about the people with whom I spent time in Khayelitsha. During the fieldwork period, Monwa introduced me to many people, which of course partially dictated the direction of my research and helped to shape the data I collected. In my experience, Monwa's respected and well-known position in his community served as research benefit in that informants often appeared to speak more openly with me when he was present. Other informants included those running their own home-based care organizations or working for existing organisations, support group facilitators, those cooking for soup kitchens and those involved in community-level activism, around HIV in particular. I made several lengthy visits to Khayelitsha where I sat with people in their homes or at their places of work, discussing their experiences and motivations as CHWs. At organizations' headquarters, while speaking to CHWs, I assisted them in the provision of services, including helping to cook and distribute soup, care for children in crèches or day cares and writing funding proposals to various national and international bodies.

CHWs, using arguments about both the naturalness of and economic motivations for caring, ease the difficulties associated with receiving remuneration for what is often spoken about as a "natural" inclination towards care. Through receiving payment for their care work roles, however small or inconsistent, care work in Khayelitsha has come to have particular social and economic value.

Gendered Natures

² When speaking to Monwa about writing this article, I asked him if he wanted to choose himself a pseudonym. He said that he wanted me to quote his full name in the article as I have done here.

In Khayelitsha, as it is in so many other places, gender is one of the strongest naturalising discourses around care. Around the world, social reproduction and gender have become a naturalized argument for why women find themselves in community health work, in addition to caring for and maintaining their own families. An extensive body of literature exists about the intersections and interactions between gender and care work. Gender theorists and feminist scholars have long explored the relationships between paid/ unpaid labour or productive/ reproductive labour, gender inequality and the “double burden of care” (Budlender 2011 and Hervey 1998). One young care worker explained the particularly gendered ways that she thinks about care: “The work we are doing is for the women. The men don’t feel as bad as women. The women feel that pain. Men feel a little bit but men don’t feel a lot. There was one man but he left and he doesn’t work with the organisation anymore.”

As many scholars have argued, it matters who the person providing the care is, just as it matters who is being cared for, and how care is provided and experienced. The carer/ caree relationship is defined by motivations for caring which are assigned by gender and social norms, the development of relationships between a carer and caree, but also by the expressions of dependence, reciprocity and friendship (Himmelweit 1999 and Held 2002).

In Khayelitsha, I have found that many women first enter into more formal care work, where there is potential for financial remuneration, as a result of circumstances requiring care in their own homes. When I asked women how they became involved in offering care-related services, many narrated painful past experiences of caring for loved ones as primary motivations for becoming involved in community health work. Many also see women as naturally “better” carers, who are more naturally inclined to do care work. Mzi who runs *Ichibi Single Mothers* used her recognition of the particular gendered roles that women play to offer them support. She wanted to “open women’s minds” and help them to rely on themselves through sharing stories, knowing and supporting other women in similar situations. The organisation started as a small support group for single mothers but has grown to include many different components, including an HIV support group, cooking for community members a few times a week, beading and sewing.

Waerness (1984) also explores the importance of the carers’ personal knowledge and experience and the ways that these contribute to the development of relationships between

those providing and those receiving care. In addition, there is no reason to think that personal attachments cannot develop in market relationships (Ungerson 1990). Mzi's organisation began as an entirely voluntary operation that relied on Mzi and a few other women's meagre financial inputs but now receives small amounts of money from various sources, including from the South African government. But the fact that the organisation receives this small amount of funding does not detract from the caring feelings of the women who work there. Instead, personal attachments and strong feelings are a central part of caring relationships, whether the care is paid or unpaid (Himmelweit 1999).

Although care work is highly feminized in Khayelitsha as in other parts of the world, some men are also centrally involved in providing the community with care, but use quite different justifications for doing so. Monwa, a local pastor, church founder and key informant in this study, played a significant role in my understanding of the ambiguous nature of care in Khayelitsha. His Christian ethic of care made it more possible for him, as a man, to perform intimate and gendered caring tasks. He often tells the story of when he first went to wash a chronically ill female patient, that it was "so painful" and how she was first silent but then deeply grateful to him for offering her care. If he was not a pastor and thus able to cross particular gendered lines, perhaps he would not have had the opportunity to engage in this caring activity.

"It's in our veins": the "African-ness" of Caring

The community response to health-related challenges in South Africa, including the HIV and TB epidemics, has also been described in terms of *ubuntu*, or a uniquely African ethic of care (Manda 2007). Many community health workers explained their engagements in care as part of this African ethic of *ubuntu*. One morning, after visiting the clinic, where an organisation of home-based carers is housed, I asked Monwa why all of those women choose to volunteer as home-based carers. He turned to me and answered, as though it was obvious, that "it's in our veins to care".

The *ubuntu* concept is central to many contemporary ideas about African solidarity and self-worth (Tutu 1995; Manda 2007). Many older CHWs have told me that *ubuntu* has been "killed off" by contemporary urban life, and the ways that younger care workers seek employment, and personal career development. Older women partly attribute the "ending" of

ubuntu to the fact that they see the younger generation of carers as self-serving. Mzi explained “It’s only the old people who have that real passion for caring for people.” When speaking about their motivations for being volunteer care workers, women invariably speak about seeing “too many sick people”, “people suffering with no one to take care of them” or the need to identify and address “problems in the community”. It has also been said that “if your neighbours’ child needs something, you must help”. For most, this links directly to a local notion of *ubuntu*. *Ubuntu* as an idea is often indexed to the Eastern Cape, rural social relationships and close family and community interconnectedness and responsibility.

This ideal is challenged in urban spaces like Khayelitsha where illness, migration, and economic deprivation make living up to the demands of *ubuntu* difficult. In times of economic marginalisation and social disconnection, often compounded by illness, it is increasingly peoples’ neighbours and wider networks of community members, rather than peoples’ immediate families, who end up responding to peoples’ care needs. Many of the CHWs I spoke with draw on the notion of *ubuntu* but put it in practice in a broader way, saying that though life in the city and in poverty makes care difficult, it is still something “in their veins” that they need to do. I was also told it is also “the home-based carers’ responsibility to help.” Although the naturalness of caring for Africans may be spoken about time and again, the care that is possible in this impoverished context is fundamentally shaped by the significant lack of resources. This discourse has in part been used to explain peoples’ continued commitment to community care, despite a lack of economic benefit.

These arguments about the perceived naturalness and responsibility of African people to care for one another have been the rationale for several different organisations. Some organisations consist of only one or two women running small HIV support groups a few times week, while other organisations in Khayelitsha have over 50 permanent employees, and are funded by large, international funding agencies (Schneider et al 2010 unpublished). But all of the women who have joined these organisations have done so in some way or another to meet the needs of fellow community members. I was told by a young home-based carer who was explaining the role of workers like herself in the community: “We like to volunteer. We don’t want to see people die. We want to help. If we not here, they will spread instead of preventing [HIV].”

Ironically, the argument about “African-ness” that is used to justify volunteering as community health workers is also used to account for the reasons why HIV is so prevalent in Khayelitsha. A Community Health Advocate for the Treatment Action Campaign explained that although “Khayelitsha” means “new home” in English, it is “a terrible place” where people have “a township mind”. He said that many of the people living in Khayelitsha are from the Eastern Cape, and have been “taught culturally”, and do not know enough about the rights and responsibilities with regards to HIV and sexual relationships. This contradiction, the idealization of “African-ness” on the one hand, and its denigration on the other, is but one clear example of the complex terrain into which caring in Khayelitsha is embedded.

A Christian Ethic of Care

All of the community health workers I have met in Khayelitsha are women, although some men, like Monwa, find themselves in caring roles. For Monwa, caring is very closely linked to his being a pastor, and for him, care is linked to Christianity, the third naturalised discourse about care. The Christian ethic of care is certainly not limited to those in leadership positions in the church, or to Khayelitsha. Care and volunteerism has been extensively investigated in relation to a Christian ethic of care in South Africa and beyond (Akintola 2010, Kegler et al 2010).

In Monwa’s small 4-roomed house, there are always many other people staying temporarily. When I first met him, 17 people were living there. He says that to open your house to people as he does is “the Christian way to do things”. In this way, Monwa is able to use the fact that he is a Christian to challenge the gendered notions of care work. The majority of people living in Khayelitsha would probably describe themselves as being “Christian”.

Monwa and his family care for people in Khayelitsha in a range of ways. He and his church members run several support groups for HIV-positive people, both in Khayelitsha and in the Eastern Cape. Monwa takes it upon himself to offer care and support to the people living in his neighbourhood, which could be seen as attributable to his Christianity, and also to his notions of *ubuntu* and African-ness. Whenever there is an illness or death of someone living his area, Monwa rallies other community members to support families that need it.

Monwa's framing of his caring practices as part of his Christianity allows him and his church members to practice care in ways that challenge some of the conventional ideas about care and about HIV. Monwa uses Christian moral principles to challenge this stigma and discrimination and works to make local churches more accepting of those with HIV. His focus on Christian care also allows him to challenge gendered notions of care work by, for example, asking male members of the congregation to wash and care for sick members in their homes. This is in strong contrast to the conventional gendered division of care work (England 2005).

Through Monwa I have met many people working with other faith-based care work organisations. Another pastor and his wife, who run a home-based care organisation, attribute its foundation to the fact that the pastor saw people being cruelly excluded from their respective churches when they were found to be HIV positive. These people were thought to have contracted HIV because they had "sinned" and were therefore shunned from the rest of the church community.

There are, however, limits to the use of a Christian ethic of care to defend the support of HIV positive patients. One local pastor who was very supportive of including HIV-positive people in the congregation was also at pains to explain to other local pastors that people can also get HIV "through an accident", revealing an ambivalence about the moral problem of HIV infection. He encouraged them to care for those with HIV, and not to exclude them from the congregation. The Christian discourse is being used to challenge the dominant discourses through which people with HIV are excluded, stigmatized and discriminated against (one of which, ironically, is also Christianity).

Economic Motivations for Care Work

Despite the strength of the naturalised discourses of care described above, there are also discourses of economic motivation for care work and these often sit in tension with more essentialising explanations. In the context of severe deprivation, where resources are scarce, people have different ways of "getting something". Although it is described in multiple and ambivalent ways, providing care has become, for many, a source of small income, or a means to access financial and social support from others. As resources are scarce, and paid care work opportunities are few, CHWs have had to find ways to understand and speak about their

legitimacy as care workers. In the section that follows, I explore the complicated relationship between the gift of care, and care work as a commodity. I then explore CHW experiences and opportunities for creating career paths or professionalization.

Community Health Work, Social Reproduction and Survival

As the naturalized discourses for how and why people become involved in care work are so strong, the first time I was told by a carer that she was doing it “because she needed a job”, I was surprised. Never before had I been told that someone’s motivation for doing care work was economic. This was, however, a common theme among many CHWs who relied on the tiny amounts brought in by care work to support not only themselves but their children and families (Nelson 1999).

But this woman’s statement was quickly followed up with explanation that she and the other women who cook the soup for the patients at the local hospital three times a week do it because they “like to help people”, and because it is “better than nothing”. Both Folbre (1995) and Frey (1997) point to the complicated ways that extrinsic or monetary motivations could be seen to force caring or affective relations into financially incentivized obligations. In the context of South Africa, where there is a need for people to perform a range a care-related tasks in order to maintain the health of the population, it is hardly surprising that the intersections between care and money come into sharp relief.

Rather than speaking about their own survival as individuals, women speak about the survival and reproduction of families and communities. As one woman explained, “We have to take our children to school but we are not after money more than we want to help the community. But we need money for crèche”. There is clearly ambivalence for these women about the economic rationale behind their involvement in care work, which is in part mediated for them if they speak about earning money in order to care for the needs of others before their own needs.

This concern with economic motivation is not only with respect to woman’s own self-narratives about care work—it is extended to other carers as well. When resources are

scarce, the ways people rationalize their involvement in care is highly scrutinized by others. The head of one small home-based care organisation said that some of the women who work for her organisation are just there because they need a job, whereas others “really want to help people”. She says that you can *see* the differences between these two groups of people. This idea of the tension between these two justifications for care work is strong.

The potential for money to corrupt or corrode “genuine” or altruistic caring relationships has been extensively explored (England 2005, Himmelweit 1999 and Nelson 1999). When looking at the naturalized discourses around care work, it is clear that there exists a problematic assumption that people only vary in the amounts or capacity that they have to care, while their costs or financial needs and attractiveness of other kinds of work, remain constant (Nelson 1999). In other words, people are only assumed to have differing natural capacities to care, while the economic demands on them remain the same. Here there is a highly symbolic divide between love and money, or between the gift and the commodity. The central question in relation to this symbolic relationship is whether extrinsic or monetary reward leads to a reduction of love or intrinsic motivation to provide care work (Ungerson 1995; Folbre 1995 and Frey 1997).

This notion feeds into the ways that carers speak about the work that they do: they need the money to survive but don’t want their involvement in care work to be seen as solely or even principally economic. The South African government’s provision of stipends to the governmentally-employed CHWs is an important part of this conversation. Ungerson (1995) writes about concepts like “honorarium” where volunteers are given symbolic payments to reinforce offering care for love rather than for money. Those receiving stipends would not be in danger of being seen as profiting off the care needs of others, but would instead be seen as gaining rewards linked to trust, respect and appreciation by the communities in which they work. By failing to make this kind of care work economically attractive, it can be implicitly ensured that those who become involved in care work are doing it out of “love” or altruism. In this way, it is clear that the relationships between “love” and “money” cannot be easily separated.

Furthermore, in the context of economic scarcity, while care may be understood as “formal”, and as “work”, there may not be adequate funds to remunerate it (Schneider et al 2008) and the line between paid and unpaid work becomes thin. In the context of scarcity, the

relationship between the gift and the commodity becomes even more tenuous as for the most part, care work cannot be paid for well, if at all. For some organisations, access to funding is becoming more difficult. Funding from the government for *Ichibi* has been cut, and now funding for a small monthly stipend has only been made available by the Department of Social Development for 6 of the 18 volunteers. Although Mzi is upset by this, she maintains that she “did not have the guts” to tell any of the women at *Ichibi* that they would no longer receive something at the end of the month. Mzi asked me “What would they do? Just sit at home with nothing? I could never do that.” Instead of telling some of the women that she could not pay them anything, Mzi split the money into even smaller portions amongst the women.

The tensions experienced between intrinsic and extrinsic motivations and rewards are not experienced only by individuals within organisations but also frame the relationships between organisations as well. When funding for care work is scarce, competition soon develops. Judgements are made about how funds are distributed or spent, and people are weighed up according to whether they are perceived to be worthy of receiving funds. When there are no funds available, there exists a clear moral economy of care, but as money becomes introduced into the system, care work becomes commodified, professionalized and more closely monitored. The amounts and ways that money is introduced bring about varied changes in the moral economy of care work. In some cases, when individuals or organisations are perceived as having too much money, accusations of corruption begin to emerge. As Mzi spoke about *Ichibi*'s funding cuts, she explained that some organisations have been getting too much funding for the wrong sorts of activities. She is angry that another organisation's soup kitchen that “was started long after” *Ichibi*, is getting more funding. According to Mzi, the Department of Social Development is now giving money to some of the “wrong people”; people who are running a business, and taking advantage of those who are vulnerable and sick. She explained to me that those working at the other organisation “are running a business. They are taking advantage of the people”.

There is also much talk about the fact that pastors must not take advantage of their congregations, and must not rely solely on church funds in order to survive. Here the tension between survival and profit appeared particularly relevant. It has been said that sometimes items donated to churches, for example, a keyboard, are later sold by corrupt pastors in order to make some money. I have been told that some pastors “drive R500 000 cars, but their

people don't even have a proper church to go to". Whether or not pastors actually drive expensive cars is irrelevant. It is the moral judgment made of those perceived to be profiting off of others that is important to recognize. Even when accumulation of wealth and ostentatious displays of it are not at issue, scarce resources may require care practices to be separated in some way from earning a living. Monwa believes that the "church people cannot be the only ones to support the pastor. That's why all the pastors must have other small businesses as well." His small way of generating some extra income at that time was to buy bags of sheep heads to get another church member to sell in order to generate a small additional income.

It is clear that community health work in Khayelitsha, and the ways that the tensions between the gift and the commodity are experienced by CHWs themselves, are complex. The fact that Khayelitsha is a context where the potential for great economic reward for care work is absent, is another important part of the conversation. Much of what has been extensively debated in the literature, in terms of the relationships between intrinsic and extrinsic reward, has been written in the first world rather than in the impoverished South African context. While there exists a tension between love and money, or the gift and commodity everywhere in the world, this tension is under particular pressure in the context of economic scarcity. In addition, in situations of economic deprivation, choice, or motivations are shaped in particular ways. In other words, choice about whether or not one "wants" to engage in some kind of care work, or whether one is providing care "for the money" are complicated in situations of economic deprivation.

As England (2005) explains, part of the way that low pay for care work is justified is through the perceived "intrinsic fulfilment" of doing care work that is perceived to make up for the low pay. The argument is that if those providing poorly paid care work were not getting some kind of other rewards for the work that they were doing, they would simply find other employment opportunities. But, in the context of extreme economic scarcity, this is often impossible. It is precisely because resources are scarce that judgements about people's legitimacy as carers, and motivations for engaging in care work, are scrutinized in the ways that they are. Perceptions of "profiting off of" others' care work needs only become relevant when meagre resources need to be distributed amongst many people.

Professionalization and Creating Career Paths

A second important economic rationale for care in Khayelitsha is to develop a particular set of skills through accessing training and gaining work experience. It is usually younger rather than older CHWs who see their volunteering in this way. Most women sooner speak about the fact that seeing sick people is “painful” than about the ways that they have been able to use their qualifications to access financial resources and further trainings. For example, one young carer who I have known for some time, only recently spoke about her work as a home-based carer as a means of gaining other kinds of employment. She used the fact that she has a high school diploma in order to enrol in a home-based care course, and now she is on her 3rd of 5 levels of training. She, like many other home-based carers and community health workers, hopes that with further training she can get a job as an assistant nurse at a local hospital.

For too long it has been problematically assumed that women may engage in poorly remunerated care work because of their innate and genuine concern, or capacity to be “more caring”. This makes women particularly vulnerable to exploitation (Folbre and Weisskopf 1998). In addition, although some may begin careers in care work thinking that there may be scope for career development, the lack of significant and sustained extrinsic or monetary incentive for this kind of work would usually mean that this kind of career development is not possible (Himmelweit 1999). The potential for further career development is certainly something that many, mainly younger CHWs speak about at length, although few have actually had access to the opportunities that they may hoped to have accessed. The danger in this situation is that women’s work as carers becomes a form of self-exploitation and undervaluation.

As a way of meaningfully participating in a competitive care work environment, many CHWs, especially younger CHWs, show remarkable resourcefulness and entrepreneurship. During a visit to a home-based care organisation, where the carers crowded a single room, I was asked if I could offer any of them some paid work in my home. One woman even offered to work in my garden; a job usually undertaken by men. She explained that she could “be like” a man in order to do the gardening job. These carers displayed innovative attempts to find paid employment, and develop career paths; one even manoeuvring herself in relation to something as engrained as gender. Their involvement in home-based care can also be seen as a site for networking with other more resourced people, as they saw me to be. This highlights

the fact that these women are not necessarily committed to engaging solely in this kind of care work.

Though many CHWs expressed a commitment to work in the field of care, their care work also often opened up opportunities for work in other areas that their economic circumstances requires them to follow. One young CHW explained that to be a home-based carer was one of “her dreams”. However, she, like many of the CHWs I worked with, would probably not have turned down another employment opportunity in another field that emerged through the social and professional networks created in care work.

Another young carer explained to me that in order to become a carer, she needed to complete her “matric” or final year of high school, after which she would participate in various “trainings”³ to improve her skill-set, and make her more employable in other contexts. This attempt to better herself, and gain skills that could be used to access resources in other contexts exist seamlessly with the notions of a desire to help the community. This carer said that she “must spread information to other people—refer people to hospitals, call ambulances, and help people to get grants. I really enjoy what I am doing. I want to help their lives, solve their problems and help them to be leaders in the community”. She wants to be a role model, and thinks that they are role models to people. As another home-based carer put it “by sitting at home doing nothing the information that you have goes out. In order not to let this info disappear, you must use it”. She said, “the volunteering will turn into a job. We are getting more skills and are therefore going forward”. These women believe that by volunteering, more opportunities will present themselves, and through having various different kinds of training, they will become more employable in a range of contexts. As Himmelweit (1999) explains, perhaps this may not be possible in the ways that these young carers imagine it to be.

Generational Dimensions of Community Health Work

There is exists an interesting generational dimension of community health work in Khayelitsha that cuts unevenly across these various discourses. By “generational” dimensions of community health work, I refer to the ways that those (predominantly women) providing

³ The coined noun “trainings” is used in this context to refer to training programs.

care in Khayelitsha, experience the work that they do, and understand their motivations for becoming involved in care work in terms of their generational position. When I refer to CHWs as “older” or “younger”⁴, I am referring to their age as well as their accumulated experience of growing up, living and working in South Africa, and more specifically, Khayelitsha. Older CHWs lived through and were attempting to find employment in apartheid South Africa. Their years of practice and earlier migration to Cape Town, significantly shaped their understandings and experiences of care (Swartz 2012, in publication). As van Ginneken et al (2010) explain the period between the 1970s and 1990s during apartheid was in many ways better than the current situation in which CHWs find themselves. In those years, CHWs were paid by the government and although it was a small amount, they were afforded job security, and remuneration.

“Older” CHWs (in age and years of experience) tend to start their own care work organisations, typically providing home-based or child care, psychosocial support or food provision through soup kitchens or cooking for families. The younger CHWs tend, on the other hand, to work as home-based carers for existing organisations, as some are now required to have a high school Grade 12 certificate (“matric certificate”) to be employed⁵. Younger women then often receive a range of trainings in home-based care which they speak about in terms of one day finding more permanent formal employment.

The issue of training and whether women have a matric certificate is contentious. Some people can only access a position as a home-based carer if they have a matric certificate, which usually means that they are younger and less experienced than those who have been doing home-based care for many years. Older carers have indignantly explained that although they may not have a matric certificate, they do not mind washing patients with terrible burns or bedsores, whereas some of the younger people “don’t even want to touch them.” The younger carers are perceived by some to be so far removed from *ubuntu* that they do not even care enough to wash the patients who are in greatest need.

There exists a great deal of tension, which has sometimes been described as “jealousy” on the part of older CHWs towards the younger generation of carers. Once, an older coordinator at a

⁴ Older CHWs would have been born between the late 1940s and early 1960s in South Africa, while those who I refer to as younger were born after the aforementioned period.

⁵ This is something that I was told by many CHWs themselves, but was not confirmed by any literature I reviewed.

home-based care organisation, called “gogo” or “Granny” by her younger staff, was reported to have said she did not want the younger, more junior staff to speak with me. When I asked why this might be, Monwa told me that she was “just jealous” that I wanted to speak to her juniors, rather than to her, and that because she was older she liked to be “in control”. Jealousy has also been spoken about in relation to the fact that some older CHWs have said that they, rather than the younger CHWs, are the professionals. On the other hand, it is also often said that the older CHWs are jealous of the “trainings” and the projects that the younger CHWs with particular qualifications get to work on.

But whether an older CHW runs her own small, partially-funded organisation, or a younger CHW works as a volunteer in an established larger care organisation, across the generational divide these CHWs are all caught in the same structural position, shaped by the severe deprivation in Khayelitsha (Thomas 2009). In their own ways, both older and younger CHWs attempt to make spaces for themselves as carers, yet their approaches to doing care work are profoundly different. Given the choice to have done things differently, in terms of accessing education and “trainings” older CHWs might have chosen the same path as the younger carers. But unable to do this, care takes on complex and ambiguous forms that have are marked and understood differently for women of different generations.

Irrespective of where and how these women work, they are caught in a structural tension where they are not fully financially recognized or valued in their positions. The complexity and ambiguity that care takes on in Khayelitsha is inextricably linked to this structural lack of recognition. Carers, both young and old, speak about their work in different ways, and also find themselves doing different kinds of activities but in the context of deprivation, these women are all marginalised, and forced to use whichever avenues they have in order to make the care work that they do tangible. They use different ways to resolve the same tension— younger carers resolve it through attempting to create careers for themselves, while older carers start their own care work organisations.

The Partial Commodification of Care Work

Through listening to the narratives of care offered up by those involved in providing care in Khayelitsha, it is clear that care is spoken about and understood in a range of complicated ways. In the process of unravelling these narratives, the lines between what is done for “love”

and what is done for “money” become increasingly blurred. Through rejecting the dichotomy between love and money, it becomes possible to explore the ways that care is partially commodified (Radin 1996; Nelson 1999; and Zelizer 1995). Genuine care always resists complete commodification, and by understanding care as being incompletely commodified, it is possible to see that care and paid labour are not opposite extremes. The rejection of the dualistic treatment of motivation (caring feelings) versus activity (caring acts) highlights the ways that many have placed too much emphasis on the capacity for choice. In impoverished contexts, where employment opportunities are few, this would be a particularly important rejection to make.

The ambiguous nature of care in the impoverished context of Khayelitsha is a product of the political and economic context, where the state has not, in the past, taken responsibility for supporting carers of this kind (Schneider et al 2008). The state’s lack of intervention has led to much overseas donor funding to various organisations in the area, as well as smaller organisations and churches bearing the responsibility of providing particular care services (Schneider et al 2010, unpublished). Those who have chosen to work in these various organisations, younger and older women, Christians working for the church, people trying to create a professional career for themselves—have all used different arguments to justify their roles within a complex network of care.

The discourses described in this article, distributed unevenly across generations, are a product of this political and economic context, in which people are trying to find a way to care for each other and to ensure the survival of themselves and their families. Furthermore, although carers speak about and understand their positions in different ways, they all find themselves in positions where they are not fully visible or recognized by the state.

Currently, however, the South African government is developing a new community health worker policy and political approach that recognizes the different roles that people play in terms of caring in impoverished conditions. Financial remuneration is one of the key features of the new policy, which was not offered before. Previous policy was to offer a small “thank you” or token stipend to carers. The government found local discourses of gender, *ubuntu* and Christian ethics convenient in justifying their failure to pay a proper salary. It will be interesting to see how the shift in community health worker policy, and specifically increased remuneration, will change the ways care work is understood and practiced in Khayelitsha.

Given the complexity of these relationships and motivations, such a plan might ease some of the existing tensions around care work while creating or exacerbating others.

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University of Cape Town

ALISON SWARTZ

SWRALI002

Masters of Public Health Thesis

Title: Community Health Workers in Khayelitsha: Motivations and challenges as providers of care and players within the health system

HREC REF: 042/2010

To whom it may concern

I have conducted a sub-study (title above) under the broader project entitled: **Exploratory Study of Community Care Worker Programmes in Botshabelo (Free State) and Khayelitsha (Western Cape)**. This broader study received ethical clearance (HREC ref above).

Signed:

University of Cape Town

UNIVERSITY OF CAPE TOWN



Health Sciences Faculty
Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
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23 February 2011

HREC REF: 042/2010

C/o Dr E Pletzen
Centre for Higher Education Development
Room 7.11, Hlanganani Building
36 North Lane, Rondebosch

Dear A/Prof Scheiner

PROJECT TITLE: EXPLORATORY STUDY OF COMMUNITY CARE WORKER PROGRAMMES IN BOTSHABELO (FREE STATE) AND KHAYELITSHA (WESTERN CAPE).

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above mentioned study.

Approval is granted for one year until 28 February 2012.

Please submit an annual progress report if the study continues beyond the approval period. Alternatively, please submit a brief of your findings so that we can close our records.

We note that Professor Scheiner has taken a position at the School of Public Health at the University of the Western Cape. We also note that Dr Ermien van Pletzen is the new principal investigator of this study. Please could you complete and sign the conflict of interest statement on our Application form (FHS013), point no.7 and return it to the HREC office. Please can you also confirm whether Dr Chris Colvin remains a co-investigator on this study?

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

Yours sincerely

PROFESSOR M.BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS
Ntsama

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