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**‘I know this person. Why must I go to  
him?’ Techniques of Authority Among  
Community Health Workers in Cape  
Town**

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# **‘I know this person. Why must I go to him?’ Techniques of Authority Among Community Health Workers in Cape Town**

## **Abstract**

*This paper forms part of a larger research project that explores how community health workers negotiate between the prescribed ‘manual’ for care and the realities of their field - re-appropriating prescriptions of public health policy through the micro-politics of everyday practice. Crucial to this question is how community health workers are able to disseminate the care manual authoritatively, despite their own authority being inherently unstable. This paper will discuss how careworkers negotiate authority in social and occupational contexts that regularly and powerfully undermine it. What tools, both discursive and otherwise, are at their disposal as they attempt to assert their authority as carers and measure up to those to whose authority they must submit? The paper shows that careworkers draw on a vast repertoire of discourses and performances in order to invoke, bargain for and appease authority. These series of improvisations are key to their survival on the job and necessitated by a care manual that is often impervious to social context.*

# Introduction

As the current standard in healthcare delivery for the poor, community health work has been widely celebrated for its ability to improve the health of large numbers at a low cost (Igumbor *et al.*, 2011; Kabore *et al.*, 2010; Nglazi *et al.*, 2011; Williams *et al.*, 2006). But this success depends on the ability of careworkers to effectively negotiate a highly complex and onerous care ‘manual’ shaped by the divergent demands of patients, employers and funders; the arduous prescriptions of policy; and dominant public health practice. Given the complexity of this care ‘manual’, this paper asks how community health workers with no professional status, no symbolic markers of authority, and no socio-economic clout, are able to disseminate it. In an effort to explore this question, the paper examines the multiple ways in which community health workers have sought to assert and bargain for authority.

Field research for this study used a range of qualitative methods that sought to examine the practice of care amongst a cohort of fifteen community health workers. These careworkers serve as antiretroviral (ARV) adherence supporters in two Kraaifontein primary healthcare clinics located on the outskirts of Cape Town. Termed ‘patient advocates’ (PAs), respondents are employed by the non-governmental organisation ‘Kheth’Impilo’, whose mandate is to support the South African government in delivering primary healthcare. Data collection included three months of intensive observation and partial job shadowing at Kheth’Impilo clinics, thirty in-depth interviews with patient advocates, three key informant interviews with managers at Kheth’Impilo, a year-long internship at the Kheth’Impilo national office, and a six-week body-mapping project with a group of six Kheth’Impilo patient advocates. Data was analysed using procedures from Grounded Theory (Glaser & Strauss, 1967). Pseudonyms are used throughout to protect the anonymity of respondents.

In care programmes across the world, including that in this study, community health workers are recruited from the same communities as their patients in an effort to make care that is accessible to community members and reflective of the socio-cultural context in which it is located. While this model may render care more amenable to patients, the everyday proximity of carers and cared-for also militates against social distance, demystifying the ascribed authority of appointed careworkers. Furthermore, without accreditation or professional status, the expertise that might underwrite respondents’ authority is called into question, both by patients and clinical professionals. Community health workers in this study also lack those symbolic markers of authority bestowed to their professional counterparts through uniforms and technical instruments.

Indeed, young black women, who make up the vast majority of the research cohort, have been systematically disempowered. More likely to be unemployed (SSA, 2012) and uneducated (DOBE, 2012), and often subject to gender-based violence (Dunkle *et al.*, 2004), the socio-cultural clout of black women in South Africa is regularly and powerfully undermined. Yet careworkers are expected to challenge traditional authority structures in the very spaces that delimit and reproduce them, unsettling the norms of homes and families, and imposing rules over sex and bodies. Both the clinic and the home are key spaces in which careworkers must negotiate their authority on a daily basis. Each of these is their own social universe, with established hierarchies, gatekeepers and rules of operating.

This paper shows that careworkers draw on a vast repertoire of discourses and performances in order to invoke, bargain for and appease authority. In order to elicit compliance to the care regimen, respondents in this study adopted a range of techniques – sometimes punitive, coercive and infantilising, sometimes supportive and empathising. These tactics of implementation re-invent, and sometimes exploit, the care manual, at times making it more amenable to patients and at other times boosting the power position of careworkers.

## **Performing Authority**

In early June 2011, while observing at Bloekombos clinic, I was fortunate to overhear a patient consultation conducted in English. Nandipha, who served as the attending patient advocate, was aware that I was listening-in, compelling her to enact an exemplary consultation. Her performance was telling, not only of her conception of the ‘model consultation’ and the mode of authority it demanded, but also of how she negotiated my authority as a researcher through this enactment.

Nandipha’s patient was initiating antiretroviral treatment, which requires that he be given a detailed set of behavioural instructions. The patient was told to take his medication every twelve hours and reminded that ARVs are a life-long commitment. He was further advised to eat fruit and vegetables, drink “amasi”(milk), avoid eating “inyama”(meat) on a daily basis and go for regular walks. “Eat healthy, exercise, use a condom and take your treatment”, Nandipha instructed, “Then your life will be perfect” (7 June 2011).

Sensing her patient was not convinced of this she said, “Do you know that HIV is not the end of the world? You can live a long life”. The patient did not respond. Instead he played with his cell-phone, seemingly disinterested.

Determined to provide some encouraging news, Nandipha asked whether her patient was thinking of having children. He answered no, but she was not satisfied, presuming his HIV-positive status was discouraging him. “Why do you not want to have children?” she asked, “How do you know your girlfriend will not want children?” Nandipha couldn’t wait to reveal her revelatory message - that even if you are HIV-positive you can have a sero-negative baby. “You can have a baby, but it must be planned. Don’t think of having a baby without consulting uqhira [the doctor]”.

Throughout the consultation, the patient appeared indifferent. He was told how to eat, how to exercise, how to have sex and how to procreate. All the while he sat in silence. Facing an unresponsive patient, Nandipha attempted to foster enthusiasm by drawing on the success of medical science, which has allowed longevity and safe reproduction for people living with HIV. She presented these achievements as a wonderful revelation, hoping it would inspire her patient to comply with the regimen she prescribed.

Given that AIDS science is the authoritative discourse of the clinic, by invoking it Nandipha fulfils the expectations of her superiors, performs her own professionalism, and exemplifies the model of care she was taught through training. My presence as an observer may also have prompted Nandipha to wield her biomedical knowledge as an authoritative tool, assuming I would endorse a model of care in which treatment literacy and the achievements of medicine are foregrounded.

For whatever reason, Nandipha chose in this instance to invoke AIDS science as a technique of authority and a compliance-inducing tool. She promised rewards, including a sero-negative baby and a long, “perfect” life should the patient observe her prescriptions. In other cases, careworkers may draw on different rhetorical strategies, sometimes encouraging and comforting patients, at other times reprimanding and threatening them, in an attempt to promote diligent observance of the clinic regimen. This paper will show that in order to assert their regularly challenged and often ambiguous authority, careworkers invoke a range of tactical, sometimes desperate, heuristic devices.

## **Ambiguous Authority**

While careworkers are ideally imbued authority by virtue of their clinic appointment, their position as lay health workers has also unseated their authority in numerous ways. Government officials continue to refer to patient advocates as ‘volunteers’, calling their training and job security into question; many careworkers believe a lack of professional qualifications discredits their

authority; and some cite instances in which their expertise have been undercut by clinical professionals. Lethu<sup>1</sup> resents having to translate for clinic staff, arguing that this is not part of her job description; Miriam<sup>2</sup> says nurses behave like ‘bosses’, rarely giving careworkers credit for their contribution to patients’ wellbeing; and Tumi<sup>3</sup> reports that clinic staff show favouritism when requesting assistance from patient advocates.

Undoubtedly the most visible marker of patient advocates’ ambiguous authority is their allocated workspace. A few months into my fieldwork at Wallacedene, the crowded shipping container that was converted into the PAs’ room was split in two. One half was designated to a staff nurse, leaving the remaining half to be shared by fifteen community health workers and their patients, making clinic-based consultations infeasible. At Bloekombos, careworkers are designated the emergency room and can be asked to leave at any time. Their rights over space are insecure and unstable – a revealing metaphor for their authority in the clinic.

While respondents’ authority is unsettled due to a lack of professional status, this is only exacerbated by the fact that patients and careworkers are of the same community. When patients are directed to Jacob for consultations, he interprets their indignation as a means of saying:

‘Ag! I mean I know this person. He stays here in Wallacedene [...] Why must I go to him? [...]’ (28 June 2011).

Hence, the familiarity of one’s careworker effectively demystifies their authority. While the clinic space may legitimise the patient advocate’s position, this is destabilised by the fact that careworkers interact with patients outside the clinic, where they are equals.

Careworkers’ membership in the community also produces mistrust, since privileged clinic information is at risk of permeating the community space. “Maybe they don’t trust you because they know you,” says Caroline. This is significant given that in most situations knowing someone promotes trust, as opposed to delimiting it. Indeed, this is the assumption of the community care model, which has been impervious to stigma and local power relations assuming an idealised community of ‘neighbourliness’.

The authority of carers is particularly precarious during home visits, when patients assert control over their homes, determining what is revealed and who enters. The interpretation of home visits as prerequisite for treatment has

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<sup>1</sup> In an interview on 8 June 2011

<sup>2</sup> In an interview on 27 June 2011

<sup>3</sup> In an interview on 29 June 2011

resulted in some patients acquiescing to them unwillingly, agreeing to a home visit at the clinic but rejecting careworkers when they arrive at their place of residence. It is significant that while at the clinic, patients submit to its authority structures, acquiescing to recommended home visits; but in the context of their own homes, where patient advocates' authority is easily demystified, patients reject visitations and are even known to chase careworkers away:

‘Some of them, they are just so cross on you. But they do admit that you can come and do the home visit [...] [But] when you go there the person is so cross. You don't know what's going on. Some of them they just chase us away. So it's so difficult' (Nandipha, 19 May 2011).

Similarly, Tumi recalls arriving at a patient's home and politely introducing herself, only to have the patient retort:

‘No no no! I'm busy. I'm busy and I don't need a PA. I told them I don't need [a] PA. Don't come again in my house, otherwise if you come in my house, there's going to be trouble' (25 May 2011).

Here the patient asserts authority over her home, threatening “trouble” if the careworker dares return. The assumption of the community health worker model is that careworkers will be well received in patients' homes given their ‘affinity’ with the community. In fact, relationships with patients are tenuous and fragile. Illustrating an atmosphere of mutual suspicion between carers and patients, Bulelwa tells of how her authority is tested, even within the clinic space:

‘Sometimes when you pass there [by the patients], or you do education, or you just standing there outside, we'll hear what they are saying about us: “These people they think they are clever. Maybe also they are HIV-positive. Why should they come to our houses?” Stuff like that. And then they spread rumours about us in the location, because you know mos that we also staying in the same community. So you find out [...] they create some stories about us also’ (3 June 2011).

In saying that respondents “think they are clever”, patients may be pointing to careworkers' performed and ascribed superiority, which is used as a means of manufacturing social distance despite living in the same community. Bulelwa's comments also demonstrate that just as patients may distrust careworkers, suspecting them of being gossipers, carers are weary of the “stories” that patients create about them. This mutual mistrust between carers and patients demands ongoing negotiation, suggesting that the application of strategies of health governance is by no means straightforward, rather highly tenuous. It will become increasingly clear that careworkers and patients negotiate their

relationship to one another through a series of ongoing *quid pro quos* – sometimes placating and bargaining, at other times challenging and deceiving, in some spaces submissive and in others coercive.

## **Unsettling Socio-Cultural Authority**

Adding complexity to careworkers' negotiation of authority is their age and gender. Having young women instruct, monitor, and in some cases reprimand older patients, particularly men, transgresses entrenched socio-cultural hierarchies. This is further complicated by careworkers' interest in highly intimate details of patients' lives, including their sexual practices.

Bulelwa, like many other patient advocates, dreads having to ask older patients about their sex lives. While the need for asking such intrusive questions is often called into question by respondents, these questions are a necessary part of patients' initiation into ART. An incomplete form will merely be returned to the culpable careworker. Responding to a question about the psychosocial screening form, which must be completed for patients to access ARVs, Bulelwa reflects on the section of the form that deals with sexual practices:

‘When you ask, “The last time you had sex, did you use a condom?” If she [the patient] was smiling, she [becomes] like [changes her expression to one of shock] especially it’s difficult when you ask an older person those questions, you see. Because us [...], we don’t sit at the round table and talk about sex with our parents [...] It’s even difficult – even if you’re watching TV and then *Bold and the Beautiful* comes on, you just see Brooke is kissing Ridge and then you just turn your face like you don’t want to see. It’s like in our culture. So it’s difficult to ask an older person, like sixty-something, ‘Did you use a condom last time you had sex?’ But ke, we have to ask them those questions’ (3 June, 2011).

For Bulelwa, the expectation that she as a young woman should ask older patients about their sex lives is contrary to entrenched cultural standards, even in her own home. She struggles to transgress established cultural norms around age, but acknowledges that her job demands it.

Negotiating age-based authority becomes even more fraught at patients' homes. Here, the limited authority bestowed by the clinic no longer protects careworkers. Homes and families have their own gatekeepers, hierarchical structures and ways of operating. Andiswa tells the story of when she first visited Amos Mbewu [pseudonym]. She had never met Amos before, but arrived at his door with a name given to her by her supervisor. When she arrived, Amos'

wife emerged in the doorway and Andiswa struggled over how to negotiate the situation:

‘So I didn’t know where to start. What must I say? Must I tell them that I’m Andiswa? Or what must I say? Then I just ask for this person [Amos] [...] Because I didn’t look at the age [...], I say, “I want Amos Mbewu”. And the old Mama looked at me [and said], “Yo! You want who?” And I say ‘Amos Mbewu’. “Who are you?” [she asked]. I said, “Yo, that’s difficult to say now Mama. Is Amos here?” She say, “Yo! Amos. Do you know Amos is my husband?” Amos is the old man. You can’t say he’s Amos. You must put something first before you say Amos [...] We have to respect old people – say uTata uAmos [...] We have to put mother and father first. Then he came and he was shocked [...] Maybe the mother thought I’m his girlfriend because children of today are dating older men’ (11 May 2011).

Here, preexisting socio-cultural authority usurps the ‘professional’ clout endowed by a position at the clinic. This is more likely in the home space, where careworkers are guests and must submit to the rules of household gatekeepers. Not only is Andiswa reprimanded for not respecting the age-based authority of Amos, she cannot draw on her limited legitimacy as a clinic worker because she fears that in naming her occupation, she may disclose her patient’s status without his consent. Because she is unable to explain herself to Amos’s wife, she is construed as a possible girlfriend, destabilizing familial relationships and calling the wife’s position into question.

While patients sometimes chase carers away from their homes or fiercely interrogate them, they are also known to hurriedly clean their houses or find a place for careworkers to sit, humbling themselves before their guests. Similarly, while in some instances respondents behave as respectful guests, at other times they report immediately asserting their authority, instructing patients on how to clean and order their home.

Age-based authority is more easily negotiated in the clinic, where careworkers are attributed a degree of legitimacy, and professional-based hierarchies are at play. On any given day, old men and women waft in and out of the patient advocates’ room, joking and mingling with much younger careworkers. Sometimes a young female respondent can be seen reprimanding an old man, who, disbelieving of the efficacy of treatment, has stopped taking his medication. She may use a stern tone or wave her finger in his face. Here, the stringent rules of the home come untied and are regularly transgressed, and conventional norms of confidentiality, age and gender are disregarded.

But patient advocates must work to maintain this clinic-based clout. Some respondents dress smartly and use technical terms in an attempt to construct and

preserve social distance between careworkers and patients. Indeed, it was once mentioned to me that aesthetic authority, determined by how a person presents themselves through dress and attitude, often determines the eligibility of prospective patient advocates.

Just as careworkers must negotiate preexisting norms around age, gender norms also shape respondents' engagement with patients. On the one hand, the assumption that women are natural carers makes their position as patient advocates more readily acceptable. On the other, care that involves instruction, reprimanding, and constant probing into intimate bodily and behavioural functions is not as easily ingested when delivered by young women. This is especially true if the patient is an older man. While respondents experience fewer difficulties asserting their authority over men in the clinic, the home space presents a significant challenge. A number of female respondents report being fearful of sexual violence when entering a male patient's home:

'When you visit, what if this person rape[s] you to this house? Because sometimes you walk alone. You go to the man's house alone. I was very scared. I was not comfortable' (Mpho, 24 May 2011).

Similarly, Janet reports:

'When it's a male [...] you can't feel comfortable [...] because I know [...] most of the males, they like to rape. So when you visited, especially when it's a cold day, he has to close the door. And he's going to say that, "No it's cold, we have to close the door". [...] So sometimes I don't feel comfortable because sometimes we have visited the one who [...] is having the signs and symptoms of – to be skollies<sup>4</sup> [...] When we ask about these scratches [on their faces] they go, "No you are not coming for this. You are coming for my health"' (25 May 2011).

The authority endowed to Janet by virtue of her position as a patient advocate is rendered insignificant in this patient's home, where she is insecure and vulnerable. Within his domain, the patient asserts control, shutting the door and reminding Janet that the scratches on his face, which she deems to be a sign of violent behaviour, are not of her concern. Only his health is within her realm of authority.

While participants say that there has never been an instance where a careworker has been raped or physically abused by a patient, some respondents have experienced sexual harassment. Male patients have overtly flirted with

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<sup>4</sup> Petty criminals or mischief-makers

careworkers, phoning them at inappropriate times and professing their love to them. In one instance, a patient pulled down his pants in front of a careworker, and in another, a careworker was invited into a patient's home despite him being naked.

Hence, by virtue of being women, many careworkers are disempowered, insecure and under threat in patients' home space. Sexual harassment can be reported to their supervisors, but many of these women have also endured sexual advances from patients. Hence, the young women in this study are faced with the challenge of appearing at least somewhat authoritative in instances where older or male patients are culturally disinclined to accept their advice.

While male careworkers do not report the same levels of insecurity and fear when entering the home, they too must negotiate patriarchal authority structures, especially in their work with female clients. Andile speaks of having to work through the "man of the house" in order to access his female patients:

'It's difficult, especially for us men, when there is a man [at the house] because when you go there - maybe lets say, the client is the woman - then you find a man there. Now actually when you knock you don't say hello to a woman. You have to first ask the man how is he doing. Now if he's not in the mood, this spoils the whole process, because you cannot just talk to the woman directly [...] You have to ask the man if you can speak to the woman' (16 May 2011).

Here, Andile's authority as a clinic worker is usurped by the authority structures of the home, which designate the male head as gatekeeper to other household members. In order to perform his job and appease the clinic authorities to which he must submit, Andile must first negotiate these household rules of operating, which determine access to his patient.

## **Negotiating Authority – Proximity and Distance**

Despite its fragility, patient advocates do have a modicum of authority derived from their employment in the clinic, their education and training, and their position as gatekeepers to medical treatment and social grants. Their limited authority can be wielded with varying degrees of success. While performed superiority can prompt resistance from patients, proximity in everyday life also means that careworkers may not be taken seriously, demanding that respondents assert their position. Anna speaks of her attempts to create familiarity and comfort in the face of presumed inequity, particularly when entering the home space:

‘When I enter a house I stay positive. When I see something not right, I try not to emphasize on it, you see. If your house is dirty [...] I won’t address it [...] If they offer me a seat, to sit - they will always do something, try to clean it, you know. Then I put myself into other people’s shoes [...] I don’t want to go in there mos high and mighty [because] I’m now a clinic worker, you see. I try to stay on their level [...]’ (Anna, 25 May 2011).

Given her position as a clinic worker, Anna is perceived by her patients as morally and socially superior, warranting that they humble themselves before her, cleaning up and offering her a seat. In order to make her patients feel more comfortable, Anna attempts to downplay the social distance between them. In other cases, respondents use their presumed authority to their advantage. For instance, Nandipha speaks about how her impending home visit compels patients to take their treatment:

‘They know that ‘Ooh if I didn’t drink my medication, Nandipha is gonna come here and tell me that [...] this and this and that will happen’ (19 May 2011)

Here, Nandipha’s authority, especially her ability to elicit threats, is used to bolster adherence. Unlike Anna’s story, in which she deliberately ignores the state of her patient’s home to make them feel at ease, Nandipha uses the messiness of her patient’s home as an opportunity to assert authority through intimidation:

‘Next time I will come and I will not find this house like this. If you continue doing like this then we’re gonna let the social workers come and evaluate the place you are staying at. How does it look like?’ (21 June 2011)

Here, Nandipha brings the home environment under surveillance, compelling patients to self-govern in response to ongoing scrutiny. Anna and Nandipha employ different techniques of authority – in one instance drawing on the proximity of patients and carers, and in another, augmenting the social distance between them.

In addition to patients’ homes presenting a challenge for negotiations of authority, careworkers must also grapple with performances of authority in clinic-based education sessions, where patients are said to ‘undermine’ carers and ‘test their knowledge’. Many respondents speak of these classes as being immensely daunting, where patient advocates are put on the spot in front of a

large audience and expected to speak authoritatively despite occasional heckling. Here, respondents must find creative strategies to be heard and respected.

Generally, careworkers opt for a lecture-style tone as a means of claiming the authoritative position. This has sometimes entailed the infantilisation of patients, enabling condescension and reprimanding. Here, even adult patients are positioned as in need of re-instruction on the very basics of life. “They don’t know what to eat, what is good, what is wrong. So you must tell them” (Mpho, 9 June 2011). Similarly, Nandipha remarks:

‘If they do wrong things, you must talk roughly to them. But if they do right, then you must say “You did well now”. So they – they are like kids at the same time, even if they are adults’ (19 May 2011).

But this authoritative technique can have counter-intuitive outcomes, where patients are less inclined to listen to carers or engage in discussion, precisely because of their performed superiority. Janet, who is noted by many patient advocates as being a highly successful educator, suggests an alternative tactic, hoping to draw on her social closeness to patients to create a relaxed, communal atmosphere:

‘What you must do when you are doing education with a patient [...]: You must just talk with them. You must be on their level. Don’t be on top [...] Try to get their opinions and try to give your knowledge. Try to share [...] mustn’t educate. And the first thing you must tell them is that you are not the teacher. You are just gonna talk with them’ (17 June 2011).

Similarly, and in contrast to concurrent attempts to infantilise patients, Sinazo says, “You don’t have to do the education like you are teaching the children at school. You’ve got to speak to them” (17 May 2011).

## **Coercive Bargaining**

Careworkers’ attempts to level with patients are not always successful in inducing compliance. As a result, respondents have sometimes resorted to coercive measures in an effort to produce acquiescence. The use of intimidation and punitive tactics to promote compliance has been well documented among nurses in South Africa (Jewkes *et al*, 1998; Wood *et al*, 1997; Mathai 1997; Kim & Motsei, 2002). Reportedly, nurses have perceived a need to assert control (Jewkes, 1998: 1781) amidst difficult working conditions, professional insecurity and patients who they perceive as “ignorant”, “abusive” and

“lazy”(Jewkes *et al*, 1998: 1788). Like respondents in this study, nurses were reported to scold and shout at patients in public (Jewkes *et al*, 1998: 1785), treat patients like children (Mathai 1997) and disregard patient autonomy (Jewkes *et al*, 1998: 1791). Thus, respondents’ adoption of coercive and punitive strategies serves not only as a means to address their own insecurities and challenges, but may also function as an imitation of nurses’ authority techniques.

Some authors (Kim & Motsei, 2002) have explained the punitive tactics of nurses as a response to the duality of being both community member and professional. This challenge is even more pronounced for patient advocates who work in community-based, rather than clinic-based settings, with less status.

Careworkers are challenged with asserting their authority where patients are disbelieving, non-adherent, disinterested and despondent. Recognising that some patients need “convincing”, Andile tells stories (whether real or fabricated) to illustrate the consequences of non-adherence and convey subtle threats:

‘Sometimes you have to create stories, or [sometimes you] tell them stories which are true [...] [You] tell them: “Actually there’s this patient who was just like you, who thought [...] she was clever”. And then you tell them, “Guess what happened? She started doing the same thing as you [...] Now she thought she was better and she started not using the medication. She got sick [...]” Just create a story and then it’s gonna be convincing [...]’ (7 June 2011).

In an attempt to persuade patients into compliance, respondents may also resort to more explicit threats, drawing particularly on their knowledge of treatment literacy and the gravity of AIDS illness should patients fail on treatment. Here, careworkers invoke the morbid consequences of consistent non-compliance in an attempt to motivate adherence through fear:

“If you don’t take this [medication] [...] this will be resistant to your body. Then you’ll be on second line. And then [if] you don’t take second line also again. [...] what line would you be in? On the line to heaven [...] because you’re gonna die”. Tell them as it is. Don’t tell them that if you don’t take medication you’re gonna get sick. No. Tell them you’re gonna die because you are gonna die’ (Andile, 7 June 2011).

Another strategy has been to present treatment literacy as a rigid doctrine, where the risks of non-compliance are portrayed as certainties. Below, Andile presents the risks of unprotected sex, which include HIV re-infection or the contraction of other sexually transmitted infections, as inevitabilities in order to elicit fear and encourage strict condom-use.

‘Sometimes you have to be straight and forward with the patients: “[...] If you don’t use a condom, you’re gonna get re-infected. Or if you don’t use it you’re gonna get other sexually transmitted diseases”. There’s no better way to do it’ (7 June 2011).

A similar strategy is employed when patients are told that they will suffer immediate and certain illness as a punishment for missing treatment dosages. Promoting adherence to treatment is crucial if respondents are to prevent patients from developing drug resistance and perform their function as carers successfully. In light of this, non-adherence has often been laden with fear-inducing rhetoric, which has positioned HIV as a virus ready to pounce should patients deviate even slightly from the treatment regimen. This has clearly amounted to immense anxiety among patients. Questions like, “But what if I’m an hour early, or 30 minutes late on my treatment?” emerge frequently in education sessions.

While it is true that even slight deviations from a prescribed treatment regimen can increase the risk of drug resistance<sup>5</sup>, the consequences of non-adherence might take weeks or months to be realised and may depend on the number of missed dosages<sup>6</sup>. Furthermore, resistance can be the natural consequence of a mutating and adaptable virus<sup>7</sup>, rather than a punishment for non-compliance.

Presenting the rules of adherence, resistance and unprotected sex as hard-and-fast allows respondents to convey the gravity of the potential consequences of non-compliance. It also offers a simplified account of the science of transmission and treatment, as opposed to presenting a case in which the effects of non-adherence may take time to be realised, and the probabilities of infection through unsafe sex vary. Hence, the rigidity of the claims functions as a technique of authority, where dogmatic instructions are more effectively ingested than the uncertainties of the body.

Gertrude, who is both a careworker and a patient at the clinic, has evidently been influenced by the fear-inducing rhetoric surrounding non-adherence. Drawing on the cultural symbolism of a snake, she explains the consequences of non-adherence like this:

‘If you don’t eat your pills at the exact time, it [HIV] multiplies. It is like a snake. It just waits for you to forget, then it does that [...] First time when I started on ARVs I used to forget the time [and think] “Oh my

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<sup>5</sup> ‘The Body’ 1(see reference list)

<sup>6</sup> ‘The Body’ 1(see reference list)

<sup>7</sup> ‘The Body’ 2(see reference list)

God! What is gonna happen?” That Sisi told me that if you forget your pills it mustn’t be an hour or two [later than your prescribed time]. It must be [...] [less than] 30 minutes or so [after the designated time]. Then I mustn’t get used to that. I must stick to my time’ (11 May 2011).

Illustrating her trepidation at deviating from the set treatment time, Gertrude exclaims, “Oh my God! What will happen?” She compares HIV to a snake – unpredictable, quick and highly dangerous.

Adam Ashforth and Nicoli Nattrass (2008) trace the clinic-based use of ‘snakes’ as a metaphor for HIV to a video-based adherence tool produced by a Yale doctoral student and widely distributed by the Department of Health (although I never heard of it being used at either case study clinic). In the video, HIV is described “as poisonous snake, sneaking up to the CD4 soldiers while they are sleeping and killing them” (Nattrass & Ashforth, 2008: 289).

While snakes have multiple cultural symbolisms in South Africa, perhaps the strongest of these is their association with a form of witchcraft called *idliso*. The symptoms associated with AIDS illness are reminiscent of assault by witches, and as a result, a large number of AIDS deaths are interpreted as witchcraft (Nattrass & Ashforth, 2008: 289). Indeed, Gertrude has invoked witches when referring to her own HIV-positive “impurity”. Interestingly, these discourses operate alongside her daily prescription that traditional medicine be rejected in favour of antiretrovirals, and her assertions that HIV should be de-stigmatised.

Thus respondents may draw on different universes of meaning in order to explain AIDS science and encourage compliance. Public health’s assumption that careworkers are converted into science-based AIDS activism has meant that the invocation of other interpretations of health and illness often goes unnoticed, although it has been increasingly documented in anthropological studies (Almeleh, 2004; Mfecane, 2010; McNeill & Niehaus, 2009).

The discussions above illustrate that respondents may threaten patients with fear-inducing and even fabricated stories as a tactic to promote compliance. The paper now turns to the ways in which careworkers exploit their limited power to bargain for, or perhaps bribe patients into, acquiescence.

A key disciplinary tool, used both to coerce patients into the care programme and promote compliance, is the treatment contract. Patients sign this document before initiating ART but after a series of consultations with doctors, counsellors and community workers. The contract commits patients to taking the medication as prescribed and appearing for regular appointments. It also consigns them to informing the clinic of new symptoms, changes in address, and

intentions to have a child, creating a sense of ‘accountability’ to the clinic that supports ongoing surveillance. Patients are reminded of these commitments when considered to be at risk of deviating, or when threatening to drop out of the care programme.

At the bottom of the form there is an option to accept or refuse a patient advocate, with the qualification that should they default on treatment, a careworker will visit them regardless of their consent. Pressure to enter the patient advocate programme is compounded by the fact that patients are guided through this contract by careworkers themselves, and that clinic staff “market”<sup>8</sup> the patient advocate programme in initial consultations. Careworkers acknowledge that acquiescing to home visits is often interpreted as a prerequisite for treatment.

The position of patient advocates as gatekeepers to the social grant system is also a crucial source of power. A person with HIV, whose CD4-count is below 200<sup>9</sup>, is eligible for a disability grant since they are presumed unfit to work and provide for their families. In theory, this grant should lessen the burden on the sick, allowing greater chance of recovery. However, careworkers report that, since patients have to be sick in order to receive the grant, some will prioritise a monthly income over their health - purposefully delaying treatment or skipping medication. This is supported by research (Natrass, 2004; Leclerc-Madlala, 2006), which shows that patients at public hospitals sometimes use poor health as a bargaining chip to negotiate for greater payout from social grants. Fear of losing their grants may prompt patients to default on treatment in order to drive down their CD4-counts.

Evidence that people will trade health for income has been called into question by researchers (Venkataramani *et al*, 2010; de Paoli *et al*, 2002). Regardless, the assumption that this trade-off produces non-compliance in patients has prompted coercive responses from respondents. On one occasion at Bloekombos clinic, a patient came into the careworkers’ room to enquire about a grant. After looking at the patient’s folder, Nandipha said, “This patient has not been to the clinic since March. If she doesn’t take her pills she can’t get a grant”.

Here, Nandipha positions antiretroviral adherence as a pre-requisite for grant eligibility. Significantly and paradoxically, adherence would likely improve the patient’s overall health, increasing her CD4-count and thereby making her ineligible for a disability grant. But in an attempt to dissuade patients from

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<sup>8</sup> Joan, Kheth’Impilo national Office, 17 March, 2011

<sup>9</sup> In the Western Cape, those eligible for the disability grant should be either at Clinical Stage 4 of AIDS (the last stage of AIDS usually evidenced in opportunistic infections) or have a CD4-count of less than 200 (in Natrass, 2004: 7)

trading off health and income, Nandipha manufactures a system of incentives, positioning social grants as rewards for adherence. So while the eligibility criteria laid down by the Department of Social Development seems to disincentivise adherence, the eligibility criteria imposed by Nandipha attempts to incentivise it:

‘You have to find something that will let this patient take the treatment. Even if they don’t take their treatment, you have to threaten by telling them that if it’s only because you got the grant [...] we gonna ask Social Development to take the grant [away], because the reason why you are not taking the treatment is because you did get the grant. So the grant is more important to you than your life [...]’ (19 May 2011).

Despite the contradictions between her own system of incentives and the realities of grant allocations, Nandipha uses her position as gatekeeper to the social grant system as a source of power, allowing her to bribe patients into good adherence by threatening to delay their application or stop their grant. Similarly, the position of patient advocates as gatekeepers to medical treatment allows significant bargaining power. Illustrating this, Thandeka lays out her expectations of patients who want to access treatment:

‘She is the patient [...] if she wants your help, she’s supposed to go with the rules of the clinic [...] If [...] she is here at the clinic, she’s supposed to come to you [and say] [...] “Okay I’m here today, I’m going to start my medication”. She can’t go there behind my back because it’s me whose going to tell the doctor that she is ready or she’s not ready’ [for treatment] (8 June 2011).

In declaring “she is the patient”, Thandeka asserts her authority and implies a set of roles and responsibilities, which must be accepted if the patient is to start medication. Here, a patient’s treatment readiness is determined by whether they “go with the rules of the clinic”. Given the threats elicited by careworkers, and their demonstrated bargaining powers, it is in the interests of patients to at least be **seen** to comply with the behaviours deemed as pre-requisites for treatment. This is perhaps why patients are reported to lie about behaviours like disclosure or alcohol intake.

‘Some of them they are liars because they need treatment. They think maybe if they [are] saying this, they’re going to get it. If they’re saying that, they’re not’ (Tumi, 29 June 2011).

Careworkers are fully cognisant of the ways in which patients manoeuvre around their gatekeeping position. Indeed, the authority tactics of careworkers

are further complicated by the counter-tactics of patients. Some patients will test careworkers' threats, while others adopt lies and disguises. In response, careworkers must improvise, juggling techniques of authority in an effort to keep patients "in the system" (Anna, 25 May 2011).

## Responsibility

The previous section demonstrated how patient advocates have attempted to manufacture distance between themselves and their patients, despite everyday proximity, using disciplinary and coercive techniques. But running concurrently, though sometimes incoherently, alongside punitive techniques of authority are a series of 'empowerment' practices, which attempt to position patients as agents 'responsible' for their own health and wellbeing.

'We can give you support, but we can't help you to get better. You have to take responsibility for your own health' (Joan, Kheth'Impilo national office, 17 March 2011).

These empowerment strategies, aim (at least in theory) to decentralise authority and manufacture increasingly cooperative relationships between patients and careworkers. Referring to the treatment contract, a fundamental disciplinary instrument at the clinic, Joan says:

'If you look at this [...] form, it's actually placing the responsibility of treatment on the patient. And I think that's what it's all about - this [patient] advocacy. It's teaching your patient that [...] your health rests in your hands, not on mine' (17 March 2011).

Reproducing organisational rhetoric, Caroline says of the treatment contract, "They [the patients] must know what they supposed to do. They must know their responsibilities [...]" (Wallacedene, 25 May 2011). Hence the treatment contract functions as a technology of governmentality (Foucault, 1978/79), compelling patients to self-govern.

While patient advocates have sought to 'empower' and 'responsibilise' patients in various ways - filing their grant applications, encouraging them to seek work, bolstering treatment literacy, and supporting them through the treatment programme - the rhetoric of 'responsibility' and 'empowerment' also functions as a technique of governance. Here, respondents invoke responsibility first as a means to elicit diligent compliance and accountability, and second, to protect the credibility of carers where patients **do not** succeed on treatment. Here 'responsibility' is conflated with acquiescence and liability - a form of

‘governance at a distance’ where patients, through technologies of ‘self-care’, take ownership of, and accountability for, their health.

In the South African public health sector, before HIV-positive patients can begin ART, they must demonstrate that they are ready to take on the necessary responsibility by completing a range of interviews, checklists and inspections (Department of Health, 2010), of which Kheth’Impilo’s treatment contract is one example. As an instance of ‘patient responsibility’, the contract commits clinic attendees to a set of behaviours and procedures, thereby serving as a compliance-inducing tool. Here, responsibility is used to position a set of obligations as prerequisites for treatment, where only ‘responsible patients’ deserve to be initiated onto the ARV programme. Paradoxically, those patients deemed ‘responsible’ are those that acquiesce to rigorous monitoring, surveillance and even punitive action. Hence, what it means to be considered responsible in practice often belies the empowerment impetus of responsibility rhetoric.

‘Responsibility’ has also functioned as a strategy for preserving authority. The transformation of AIDS care from palliative services to chronic illness management has required that the meaning of care as ‘tending to the sick’ be rethought. Owing to introduction of publicly available antiretroviral treatment, today AIDS care must incorporate ‘tending to the healthy’ within its mandate. In place of an image of AIDS care that evokes bedridden patients, the introduction of antiretrovirals has come with the promise of life and health. The rhetoric of ‘living positively’ on ARVs implies that morbidity and mortality are something of the past; however this is not the case, as careworkers continue to grapple with advanced AIDS illness and death. In order for careworkers to maintain a modicum of authority, their daily assertion that ARVs give you life must somehow continue to hold legitimacy despite death and severe illness.

Patient advocates must find ways to come to terms with unsuccessful care – whether in the form of deviant patients, helpless cases, or the deceased. Cases of treatment failure call carers’ abilities into question, both among patients and clinic authorities. Given that careworkers have limited power and unstable authority, which in turn limits their ability to control the choices of their patients, deferring responsibility can preserve their credibility where care is unsuccessful.

Miriam’s explanation of Kheth’Impilo’s treatment contract provides an example of how conceptions of responsibility are used in connection with non-adherent or deceased patients. Here, the treatment contract, which is the document most emphasised in relation to responsibility, is construed as aligning responsibility with liability, so that the fate of the patient may not be seen as a reflection in the

quality of care provided. Unlike Joan, who spoke of the contract as an instance of the patient taking responsibility for their own health and linking this to the patient's sense of empowerment, Miriam suggests that in placing responsibility with the patient, the key function is to absolve the clinic of blame:

‘The purpose of that contract is [...] when the client drops on medication and he became sick, like maybe for instance he died [...], maybe my friend took the medication and died and [then] the [family of my] friend claims at the police station. So you - our organization - have to have a proof, a signature that the client say, “Yes. I can start ARV medication”’(24 May 2011).

Here, Miriam understands the signing of the treatment contract to be a form of indemnity. Through the contract, the patient demonstrates that they are entering the antiretroviral programme knowingly, at their own risk, and with the responsibility of adhering to it. Miriam speaks specifically of a hypothetical case in which family members of a patient who has passed away might blame the clinic, arguing that the medication caused the patient's death. In this case, the consent form would serve as proof that taking the medication was the patient's choice.

Hence, in order to re-assert their authority and maintain credibility in the eyes of superiors, carers can be seen to defer responsibility to patients where care is unsuccessful. Non-compliance is termed “irresponsibility”. Referring to a patient who has defaulted on treatment, Anna says “She's irresponsible. She takes her medication whenever she wants to and comes to the clinic whenever she wants to” (25 May 2011).

While ‘responsible’ patients acquiesce to regular monitoring, it is paradoxically ‘irresponsible’ patients who are attributed the most ownership of their behaviour. Careworkers say in resignation, “it was the patients choice”, “we can't force them to take the medication” or “that is their right”. Hence, in cases of unsuccessful care, there is a clear authority reversal, where the patient has ultimate authority, and thus accountability, over his or her own choices.

‘If she decided not to come to the clinic and fetch the medication, there's nothing we can do [...] So you can't force. It's their own right [...] They do whatever they like. We please them’ (Nandipha, 19 May 2011).

The suggestion here is that when patients make poor health decisions, careworkers are compelled to submit to their wishes. A similar authority reversal is evident when careworkers invoke corporate rhetoric by arguing, “The client is always right”. Under this conception, it is the carer who must submit to

the authority of the patient. The use of rights rhetoric is also interesting here, since the struggle for antiretroviral treatment in South Africa drew heavily on rights-based discourse (Mbali, 2005; Zivi, 2012). Activists positioned ARVs as a human right, premised on the constitutional right to health. But at these case-study clinics where ARV treatment is now publicly accessible, medication is positioned primarily as a responsibility and patients are expected to demonstrate appreciation for hard-won antiretrovirals.

## **Discursive Authority**

In preceding discussions, I made reference to careworkers' invocation of different universes of meaning to imbue their prescriptions with authority. Nandipha drew on the achievements of medical science in her attempt to encourage compliance from her patient, while Gertrude referenced the cultural symbolism of a snake to explain ARV resistance. In both cases, respondents used fragments of discourse as techniques of authority, hoping that these languages would resonate for patients or in other cases, appease clinical professionals.

Both Wallacedene and Bloekombos are religious communities, where charismatic Christianity is reported to predominate. Thus, respondents have borrowed rhetorical and performance strategies from the church to wield as authoritative tools. Other authors, including Steven Robins (2006; 2008) and VK Nguyen (2004; 2009), have compared AIDS activists, lay health workers, and treatment literacy practitioners to 'missionaries' of AIDS science. This literature speaks about activist-carers as 'converts' of AIDS science, incorporating evangelism, confessional technologies and ritualised conversion into antiretroviral adherence support programmes. The discussions to follow call this literature into question, suggesting a tactical adoption of AIDS activist and evangelistic rhetoric, as opposed to a commitment to the biomedical orthodoxy.

It is precisely because careworkers and patients are socially proximate that they are able to select rhetorical and performance strategies with local relevance. The tactic of rendering AIDS science through religious metaphor situates AIDS care within a universe of meaning that already carries entrenched authority. For example, Sinazo reports using a 'miracle' narrative to encourage her patients to adhere to antiretroviral treatment:

'There is this thing that I always tell [patients]: " [...] If you can stick to this treatment, you can take your treatment for about six months, [...] then the viral load is thrown from your blood, showing its lower than detectable. Then you can go for an HIV test [and] you can find that [...]

there is no virus in your blood [...] The medication has suppressed the virus [...] So that's why when you stick to the treatment, even if you can go and test somewhere else, they will say you are HIV-negative even though it's [just that the virus is] undetectable” (17 May 2011).

Here, Sinazo informs patients that if they adhere to ARVs, the extent of viral suppression will result in them testing HIV-negative. This is factually inaccurate: While a patient's viral load may be undetectable, as Sinazo correctly points out, they will not test negative in an HIV antibody test<sup>10</sup>. Although Sinazo is misinformed about how viral load and HIV tests work, she moulds her pitch to resemble the miracle testimonies of local churches, since these are the healing narratives with which AIDS science must compete.

Patient advocates report that after miraculous healing rituals at local churches, followers are sent to the clinic to test, in order to prove that they are now HIV-negative and give testimony to their miracle. While I was observing at the clinic, a patient like this came to test. Andiswa told me that the patient had decided to stop ARVs because God had granted her a miracle and freed her of HIV. “Is that what she believes?” I said. “Yes,” Andiswa answered, “because she came here and tested negative.” Above, Sinazo uses the same discursive strategy in order to position antiretrovirals as miraculous and encourage better adherence, despite parts of her argument being factually inaccurate.

More explicitly, Anna uses the metaphor of an angel to designate antiretrovirals as extraordinary and transformative. She says to her patients, “If you want this medication to lift you, you must take it yourself and stand up for this, because this is like an angel for you that [will] help you in life” (25 May 2011).

Although it may be unintentional, there are also significant correlations between religious practice and the daily education sessions at the clinic. Early in the morning in the clinic waiting room, a careworker stands before patients and delivers the education session like a preacher. One respondent even describes her role as being a ‘Jesus to others’ (27 June 2011). Patients sit in long pews, waiting for their name to be called to collect their treatment. When their turn comes, they stand to receive their medication from the nurse. The procedure is reminiscent of the Eucharist, in which the church congregation waits to receive communion at the altar. Communion commemorates the resurrection of Jesus Christ, giving the ceremony a redemptive quality. In this case, antiretrovirals are positioned as offering ‘new life’. Patients are instructed to relinquish behaviours like alcohol, smoking and drugs, and are encouraged to live their lives in

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<sup>10</sup> ‘The Body’ 3 (see reference list)

collaboration with the clinic. Antiretrovirals, along with the prescribed behaviours of ‘positive living’, are offered as a form of deliverance.

## Multiple Healing Narratives

In addition to patient advocates’ tactical use of religious rhetoric, Christianity is also a very real part of respondents’ belief systems. Furthermore, careworkers’ religious beliefs coexist with their daily promotion of empirical AIDS science, acknowledging a world that is part faith, part fact.

Illustrating the place of religious conviction in her work, Anna explains how she responds to the risk of contracting illness from her patients. Careworkers are frequently in contact with patients with TB, yet they rarely wear masks. Furthermore, encounters with patients most often occur in small, poorly ventilated rooms, which makes the risk of infection more pronounced. Anna responds, saying:

‘I’m a praying person, you see [...] My Master’s with me all the time [...] Maybe this is not part of my job description [...], but when I go to a house, on my way there [...] I sing, I pray, I sing, I pray, I sing [...] It’s not in my job description. It’s just to keep me strong. I know where I’m going to now [...] and sometimes I need strength. I know immune tablets or boosters won’t help always. But I’m not taking any of it you see. So I’m a praying person. I like singing. I think that’s the healing part for me’ (25 May 2011).

Here Anna conceptualises praying as a form of protection against contracting illness. She “knows immune tablets and boosters won’t always help”, so as an alternative Anna prays. This belief operates alongside her daily propagation of AIDS science, which explains the contraction, prevention and treatment of disease using scientific, rather than spiritual, explanatory tools.

When Andiswa reflects on her experience as a patient and careworker at the clinic, she uses the analogy of spiritual transformation. Borrowing metaphors from the church, she comments that her work “uplifts her” and that Kheth’Impilo has shown her the “light” (11 May 2011). Also drawing on the power of prayer, Andiswa explains how she understands the relationship between religion and treatment:

‘If you are [living with] HIV, you just pray that God helps you to take your treatment correctly -that he blesses treatment to heal you’ (11 May 2011).

So Andiswa posits a relationship between the efficacy of her treatment and the will of God. Furthermore, when Andiswa described to me the patient who had professed that God had cured her, she fully believed that a miracle had occurred. Such beliefs are held concurrently with a scientific understanding of how antiretrovirals work.

So despite propagating the efficacy of antiretrovirals in their daily work, and being trained in advanced AIDS science, patient advocates hold multiple understandings of healing. While telling patients that they should not use traditional medications in combination with ARVs, some careworkers themselves believe in witchcraft and bad omens. Furthermore, while respondents dismiss local churches' assertions that ARVs are dangerous, many are also fervent churchgoers. Hence, it appears that some careworkers, like many of their patients, employ multiple healing narratives in order to make sense of a complex epidemic.

In addition to subscribing to faith-based ontologies, most respondents are able to convincingly reproduce scientific AIDS talk and a reverence of ARVs:

'I'm feeling so good because the ARVs are working. They are working really [...] I saw in my clients that others they were on wheelchair, not working, not walking. But now they are doing some business, they are working with these ARVs' (Caroline, 8 June 2011).

Wielding AIDS science as a technique of authority, Sinazo tells of an occasion where she challenged AIDS "myths" using knowledge from her training:

'During the week [...] two girls were chatting with this other guy about HIV. They say "Haai man. This HIV just came from America with a white guy". And then I just ask "Where did you get that?" They know it from just around [...] Sis Thandi [the trainer] told us where does HIV come from and then I just tried to explain so that they could see it this way. And then I really enjoyed it because I was taught by the best. I was taught by the best people [...] and then they've done their research very well. At least now I could speak some facts when the other people are speaking the myths' (17 May 2011).

The myth Sinazo makes reference to in this excerpt resonates with genocidal conspiracy theories that HIV was manufactured by whites to control the African black population (Steinberg, 2008; Niehaus & Jonsson, 2005; Nattrass, 2012: 69). Correcting conspiracy beliefs has become a priority for AIDS activists (Geffen, 2010; Nattrass, 2012: 149) in order for them to assert the biomedical

paradigm and campaign for AIDS treatment. In this excerpt, Sinazo fits squarely within this activist model, demonstrating a sense of pride and gratification at being able to wield the ‘truth’ of Western science in the face of African myths. Her pride stems from the authority of her training, which she believes is ‘the best’, situating her among an educated elite able to dispel ignorance and misinformation about AIDS. The ability to evangelise using Western science gives Sinazo a sense of authority— an ability to “speak facts while others are speaking myths”.

While there are many instances of careworkers ‘talking the talk’ of AIDS activism, there are also respondents who confessed to be sceptical of the antiretrovirals they promote on daily basis. Lethu expresses her concerns about the medication, saying:

‘What I feel about the ARVs, on my own views, on my own, never mind the fact that I’m Kheth’Impilo and I must tell the client: These ARVs to me are -What I don’t like about the ARVs is the fact that if you took the ARVs today, then if you didn’t take tomorrow, you get sick. Honestly I see them as sort of a demon or something because you can take the medication today, then if you didn’t take it tomorrow, there is something that is going to blow’ (8 June 2011).

Here, Lethu gives further evidence of the fear-inducing rhetoric of non-adherence, illustrated earlier in the paper. Repeating the widely disseminated threat that slight deviations in treatment can amount to immediate illness, she believes “something” would “blow” or “you [would] get sick” if you forgot one day’s medication. From the outset, Lethu is careful to differentiate her own disillusionment with the treatment from the clinic position, repeating the phrase “on my own, on my own”. The suggestion here is that Lethu, as a representative of Kheth’Impilo, must espouse their discourse in her daily work, but in her own opinion, ARVs are scary. She cites specifically the need for strict compliance to medication in order to stave off illness, positioning ARVs as a dependency.

Andile also expresses doubts about the medication, saying that if he were HIV-positive, he is not sure whether he would take antiretrovirals:

‘The whole thing about taking medication: I’m not a medication guy. I don’t use medication. I don’t use that muti [traditional] medication. I don’t use Western medication’ (7 June 2011).

For patient advocates like Lethu and Andile who have concerns about ARVs, convincing patients to initiate or adhere to treatment is challenging: “She [the patient] must not see that I also see I won’t take [the pills]”, says Lethu. Hence

in cases such as the ones described above, it seems as though the promotion of ART is adopted pragmatically in a work-related context, despite whatever doubts careworkers may feel about the regimen.

That respondents hold multiple conceptions of healing is a function of their being positioned between two social domains: first, the clinic where biomedicine is the normative framework, and second, their communities where Christian and traditional spirituality predominate. While this situates careworkers as useful intermediaries between the abstract prescriptions of the care strategy and the context in which it is applied, programmers who prescribe a seamless imposition of standard public health discourse often overlook this aptitude.

## Pragmatic Performances

I asked Jacob, who says that ‘ARVs are good drugs’ that can ‘take people from bad to good’ (28 June 2011), what made him so open to learning about antiretrovirals. He responded:

‘I don’t know. I’m not sure how to answer that, because I won’t say there was something that made [me open to it]. As I said, I started on this job as a job, as any job. When you are working, in order to earn money at the end of the day, it’s just all about that’ (29 April 2011).

Jacob admits that he assumed the discourse of antiretrovirals as a necessary ‘tool of the trade’, rather than being converted into the clinic belief system. Over time, he came to “understand ARVs” and the “importance of them”(29 April 2011). But initially, his propagation of AIDS science was purely pragmatic. For a significant number of patient advocates, this appears to remain the case. Despite concerns about antiretrovirals, some careworkers will promote them unwaveringly as a necessary job requirement.

Illustrating the extent to which the propagation of ARVs serves as an instrumental, context-specific performance, Andile uses the following metaphor:

‘Sometimes I feel like I’m wearing a suit. When I’m at home, this [work] suit, I just take it off [...] I don’t speak about what’s going on with work. I don’t preach [...] I do say to my friends, “You should use a condom [...] It’s better to be safe than sorry”. Stuff like that, normal stuff [...] I don’t speak about ARVs [...] It’s very difficult [...] You’ll find that someone is a patient there at our clinic and you know him or you know her very well [...] You find that you are sitting on a tavern with them. They are

drinking alcohol. We are sharing the same table. They pour and drink. I pour and drink. Then what should I say? Do I have to say something?' (7 June 2011)

Andile's insight that careworkers don a "work suit" is a profound metaphor for the everyday performance of authority that their job demands. It is this performance – tactical, adaptive and sometimes desperate – that determines their success as carers, rather than their subscription to any particular orthodoxy. Outside working hours, Andile removes his authoritative 'suit' and slots into the practices of the tavern. But it is precisely his ability to remove the "work suit" in the community, that threatens to demystify the suit in the clinic. The 'back and forth' between community member and clinic worker calls into question the reach of patient advocates' authority. During which hours, and in which spaces, is it legitimately wielded, and when (if ever) should the suit come off?

## Conclusion

This paper has shown how careworkers' application of the care manual depends on their ability to assert authority in social and professional contexts that regularly unseat it. Careworkers' position as lay workers has resulted in them feeling undermined by clinic staff and has compromised their rights over space. Furthermore, respondents have had to negotiate gender- and age-based hierarchies that disincline older, or male, patients to recognise the authority of young female careworkers, particularly in the home space. In response to the disciplinary and highly intrusive tactics of careworkers, patients have deployed their own counter-tactics – chasing respondents from their homes, making their own threats, and deceiving clinic authorities.

In an effort to negotiate this contested social terrain that makes the implementation of the care manual all the more precarious, careworkers have adopted a range of adaptive manoeuvres, both re-inventing and exploiting techniques of governmentality (Foucault, 1978/79). Respondents have drawn on fragments of religious, traditional and medical discourse, often in combination and in unintended ways; they have deferred blame where their tactics have been unsuccessful; and they have held up social grants and medical treatment as bribes. Through an ongoing series of *quid pro quos*, careworkers bargain for, appease and assert authority. This repertoire of authoritative tactics is often improvisatory and unplanned, and success is by no means deterministic. Neither then is the care strategy, which is rendered through the tactics of careworkers, taking on an unintended form in response to the complexities of context.

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The CSSR is an umbrella organisation comprising four research units:

The **AIDS and Society Research Unit** (ASRU) supports innovative research into the social dimensions of AIDS in South Africa. Special emphasis is placed on exploring the interface between qualitative and quantitative research. Focus areas include: AIDS policy in South Africa, AIDS-stigma, sexual relationships in the age of AIDS, the social and economic factors influencing disclosure (of HIV-status to others), the interface between traditional medicine and biomedicine, the international treatment rollout, global health citizenship, and the impact of providing antiretroviral treatment on individuals and households.

The **Democracy in Africa Research Unit** (DARU) supports students and scholars who conduct systematic research in the following four areas: public opinion and political culture in Africa and its role in democratisation and consolidation; elections and voting in Africa; the development of legislative institutions; and the impact of the HIV/AIDS pandemic on democratisation in Southern Africa. DARU has also developed close working relationships with projects such as the Afrobarometer (a cross-national survey of public opinion in fifteen African countries) and the Comparative National Elections Project, which conducts post-election surveys over 20 countries across the world.

The **Sustainable Societies Unit's** (SSU) mission is to explore the social and institutional dimensions of economic development and the interaction between human society and the natural world. Focus areas include: winners and losers in South African economic growth and the interplay between ecological and economic concerns. The SSU was previously known as the Social Surveys Unit and still works on a number of survey projects, including the Cape Area Panel Study.

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