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Article

Care and caring: (by) force or (by) fiction

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The global spread of Covid-19 has been accompanied by a grand-scale ‘call to care.’

Each of us has been asked to *care about* the risks and costs of the pandemic; to *care for* those in our homes, particularly children unable to attend school; and to *take care* by following public health precautions. Meanwhile, global health policy, domestic regulation, international trade, and the everyday practices of households and businesses have been reconfigured, all, purportedly, in the interests of care. The burden of care has fallen particularly on those workers recently classed as ‘essential:’ who sustain our towns and cities, feed and protect us, offer medical and palliative services to the sick, and, yes, bury the dead.

Paying attention to care – including what is, and is not, done in its name – can uncover truths about the ways that social orders assign importance. If we want to learn about what matters to a social order, a good place to start is by asking:

Who cares? (ie How are caregiving responsibilities allocated?);

About what? (ie What constitutes care?);

And why? (ie Which moral rubrics are informing how care *givers*, care *recipients*, and care *provision* is defined?)

Care, rather than being a benign or pastoral question, is a political battleground. It is in the terrain of care that we ultimately decide what matters to us, and what *will* matter to us, in the months and years to come.

In this contribution, I explore how the South African government has organised, distributed, and articulated care in a time of Covid-19, revealing the multiple, often ill-fitting, normative frameworks that undergird its response. Some aspects of this response have seen care mobilised in ways that, paradoxically, de-centre both caregivers and ordinary people; while

others have presented noticeable ruptures with the status quo, inviting us to re-imagine a more caring way of being.

Through the medium of fiction; I use the final section of the paper to articulate what a genuinely care-centred social order might look like. Writing *from*, and not simply *about*, a new public orientation towards care, serves to remind us that existing social formations, rather than being inevitable, are in fact wholly contingent. Understanding this, is indispensable to a ‘politics of the possible.’

Who cares?

If Covid-19 has entailed a ‘call to care,’ one of the first questions for governments to answer is: ‘What constitutes care in this moment and who should provide it?’

In crafting its Covid-19 response, the South African government has (both implicitly and explicitly) offered a range of answers. I will work through what I consider the most salient of these ‘answers,’ surfacing the ideologies and assumptions that inform them.

My analysis will also signal continuities and ruptures with the pre-Covid era, the so-called ‘old normal’. The Covid-19 response has smoked out many long-standing ‘abnormalities’ in our approach to care. Where we have been let down, this is, for many, not anything new. But, by de-naturalising that which had become naturalised, the pandemic also presents what Arundhati Roy (2020) famously dubbed ‘a portal: a gateway between one world and the next’.

‘The People’ should care

Among the most conspicuous responses to the question of ‘who should provide care’ in the time of Covid-19 is: ‘the public,’ in the form of individuals, families, and ‘communities’.

Covid-19 public health messaging has pivoted on prevention through self-regulation. Populations have been encouraged to curb infections by washing hands, wearing masks, sanitising, and maintaining ‘social distance’. Over the course of 2020, the South African government has called upon individuals, homes, and neighbourhoods to take up the mantle of care by observing these public health precautions, educating themselves, and shouldering the ‘sacrifices’ that national lockdown has entailed.

Much of this has been rationalised in the language of ‘personal

responsibility’ – what health sociologists would term ‘responsibilisation’ or ‘responsibilised citizenship’ (Beckmann 2013, Colvin et al 2010). Only four days into South Africa’s lockdown, the language of responsibility was in high gear. In one of his increasingly-commonplace addresses to the nation, the president commended the public for ‘responding *responsibly*’ to the lockdown, ‘observing the regulations and exercising the *greatest of care*’. Over the course of 2020, these televised addresses became a key rhetorical device through which government petitioned its people ‘to care’, often drawing on ideas of citizenship, sacrifice, and service.

The idea that ‘the people’ should take charge of caring for themselves, their families, and their communities, has one primary rationale: the state cannot do it alone.

Long before Covid-19, South Africa was already facing a ‘quadruple health burden’ (Mayosi et al 2009), with concurrent HIV, TB and non-communicable disease epidemics, along with worrying rates of violence as well as maternal and child mortality. In light of this, policy-makers have sought to transfer responsibilities for healthcare onto individuals, families, and communities with the intention of promoting ‘cost-efficiency’ and relieving pressure off an under-resourced health system. Similarly, the imperative of ‘flattening’ the Covid-19 ‘curve’ is geared to prevent overloading formal healthcare.

This is not to undermine the importance of these measures. But simply to acknowledge that shifting care responsibilities to ‘the people’ has often rested on two precarious assumptions: the first is that an individual’s ability to act ‘responsibly’ is a matter of empowered choice, negating the many social or financial constraints that might constrain this choice-making. In South Africa, we learnt early on that ‘isolation’ was more practical for those with more than one bedroom; social distancing was more achievable for those who didn’t have to queue for wages and social grants; hand-washing more attainable among those with access to water; and well-timed grocery shopping more realistic for those who didn’t live from one pay-cheque to the next.

The second assumption informing the divestment of care responsibilities to ‘the public’, is that families and ‘communities’ are ‘resilient’ enough to carry these additional care burdens.

While the president described a ‘deep reservoir of resilience’ that South Africans could activate during this time of ‘crisis’, by the first few weeks of lockdown, this alleged ‘resilience’ was looking fragile. Nearly half of

those interviewed in a rapid national survey reported that their households had run out of money to buy food during April 2020 (Spaull et al 2020). This was despite a grand-scale state relief package attempting to shield the most vulnerable. By June, three million South Africans had lost their jobs (Spaull et al 2020).

Meanwhile, a significant childcare load was shifted from the paid economy – schools and daycare centres – to the unpaid economy. Parents, siblings, and extended family took on added caregiving responsibilities. By June 2020, women were more than twice as likely as men to be taking care of children, preventing the carer from going to, or looking for, work (Spaull et al 2020). In families where jobs were lost, the burden of caregiving was compounded by having fewer financial (and arguably psychological) resources for care, even if there were more adults on hand to provide it.

Covid-19 lockdown has reminded us that each person exists within a fragile care ecology. National lockdown, enacted to protect citizens from illness and death, has also affected other pieces of this ecology, necessitating certain trade-offs – some anticipated, others not. Livelihoods have been compromised; and caregiving burdens displaced. While being unable to attend schools, universities, and daycares, many youth were cut off from vital sources of socialisation, psycho-social support, nutrition and play. Lockdown also hamstrung the informal food system, run by, and for, the poor. A resilient care system means maintaining and repairing as much of this care ecology as we can, since each piece rests on the other.

Owing in part to histories of migrant labour, deepening joblessness, and AIDS, South African households have long had fluid childcare arrangements, with multiple adults shouldering caring roles at different times in a child's life (Henderson 1999, Ross 2010). Meanwhile, 'stretched' households, which include non-resident members, have often absorbed these members in times of illness or unemployment (Posel and Casale 2020).

While families might call upon pre-existing repertoires of care to attend to the exigencies of Covid-19, we dare not romanticise or over-estimate these caring capacities. For the majority of South Africa's impoverished households, to 'show resilience' is simply to regain a 'chronically insecure form of household viability' (Marais 2005:7). Those families that do find ways of 'coping' are often only salvaging the status quo – a condition which was precarious to begin with.

Community health workers should care

In South African primary healthcare, relieving pressure from the formal health system, has meant shifting key tasks from professionals (nurses, doctors, etc) to community health workers (CHWs). CHWs are recruited and trained to provide primary healthcare within their own neighbourhoods. Their work includes household screening, treatment adherence counselling, psychosocial support, health education, palliative care, and referrals to higher-level services. With Covid-19's arrival, CHWs were posted to the frontlines, positioned as South Africa's 'secret weapon' in the 'fight' against the pandemic (Foster et al 2020).

Community-driven primary healthcare, in which CHWs play a central role, is now best practice for making care more accessible and affordable in 'under-resourced settings'. This approach to care has been informed by a host of progressive agendas: diverting from care that is top-down and centralised, towards care that is contextually-specific and driven by public participation.

But as CHWs have been folded into the project of mass healthcare provision, so too has their work been co-opted to serve diverse political and managerial agendas. Indeed, this approach to healthcare delivery has not been unambiguously *caring*.

By shifting the locus of care onto lay health staff, a significant burden of care is displaced onto a poorly paid, unprotected, cohort of workers, many of whom contend with the same social, financial and psychological pressures as their patients. The majority of community health workers are neither permanently employed, nor unionised. When the pandemic hit, many reported (October 2020) being 'afraid to work', having not been provided the appropriate protective equipment – a problem that had also characterised the pre-Covid era. Despite the risks and hardships of their everyday work, many CHWs receive no paid sick leave, nor other employment benefits. As a consequence, the frontlines of the South African healthcare system are shouldered by cheap (sometimes free) labour, subsidised primarily by poor black women: a history that is all-too-familiar.

In the era of pandemic, community health workers have been classed among South Africa's 'essential workers' to whom the President paid tribute in the early days of lockdown:

We would like to thank our nurses, doctors and other health workers – our volunteers and NGOs. The 18,000 security personnel, the farm workers who are helping to keep us supplied with food, the technician in the power

station working to keep the lights on. I speak of the caregiver who comes in every day to tend to the most vulnerable of our citizens, I speak about the taxi driver, the refuse collector, the bus driver, the supermarket cashier, the hospital cleaner, the petrol attendant and all those essential service workers – you are our unsung heroes and we salute you.

These contingents of workers are among those who the anthropologist David Graeber (2019) broadly defines as ‘the caring classes,’ in opposition to ‘the managing classes’.

Covid-19 has revealed whose work truly matters for the repair, upkeep, and nurturing of society, and whose does not. It has also revealed that those who matter most in this respect are paradoxically least valued, in terms of pay, recognition, and protection. Meanwhile, the ‘non-essentialness’ of much of the economy has been brought into sharp relief. Large swathes of administrators, middle-managers and consultants – those whose jobs Graeber (2018) defines as ‘bullshit’ – discovered that halting their work made little or no difference to others whatsoever.

This begs a reorientation of value in our economies: one that is not determined by the market, but rather by the ways in which human beings take care of one another, by providing the basis for a meaningful, nourished life.

Care through data

In addition to community health workers and the general ‘public’, one of the key agents enlisted in the project of Covid-19 care has been data, and its associated technologies. A data-driven approach to care is nothing new, but consistent with the steady rise of what David Armstrong (1995) termed ‘surveillance medicine’. Here, the medical gaze is expanded from patients to populations, from sick people to also include those ‘at risk’. Under the auspices of surveillance medicine, threats, symptoms, and behaviours are mapped and managed, and care increasingly becomes a matter of governance.

In the time of Covid-19, data-driven care has been central to contact tracing, as well as the identification of ‘hotspots’ and ‘super-spreader events’. South Africans have received regular statistical reports documenting case numbers, new infections, and deaths. Here, care is approached as a technical question: a matter for bureaucratic surveillance, risk management, and scientific modeling.

Community health workers, who screen for illness, trace contacts, and educate on prevention, are often at the forefront. Historically, this has been accompanied by a host of data-driven demands, requiring that CHWs fastidiously document and report on their engagement with patients, tracking monthly ‘stats’, and meeting pre-defined targets (di Paola and Vale 2016). Health workers, at every level of the system, find that they now have so much paperwork that they cannot care for their patients (di Paolo and Vale 2016). When time *is* spent with patients, it is often consumed by mandated form-filling and data-driven efficiency, rather than attentive, contextually-informed care – for which community health workers are uniquely equipped.

Indeed, care – as a matter of technical governance – risks producing approaches to care that are jarringly un-human. Recent trends (KPMG 2017) to *cost* the impact of gender-based violence on the GDP are one such example, suggesting that a good reason to *care* about gender-based violence is its effect on the economy. The perverse application of technical, efficiency-centred language to gender-based violence resurfaced in the president’s address in September 2020. Following his standard Covid-19 update, the president voiced his determination to ‘deal with the scourge of gender-based violence and femicide’. Here, the language of data-driven Covid-19 governance was seamlessly transferred to what government was now calling South Africa’s ‘second pandemic’: gender-based violence. ‘Based on the *latest data*’, the president announced, ‘we have identified thirty *hotspots* around the country where this problem is most rife’ (emphasis added).

The language stripped gender-based violence of any of its social origins, treating it instead as an unexplained pathogen, that had landed on the petri-dish of South Africa, ripe for targeted intervention. While the shortcomings of this singular, data-driven approach to care might be plainer when applied to gender-based violence, they are equally worrying for Covid-19, or any other question of care. Narrow technical constructions of care can negate, or conveniently obfuscate, systemic causes of ill-health. In the case of Covid-19, this means diverting attention away from the social structures that make for vulnerability to the pandemic in the first place, including the shoddy and unequal provision of the basic conditions for health and wellbeing.

Care through security

During a time of Covid-19, notions of ‘care’ have also been operationalised by those outside the traditional care economy, including the 18,000 ‘security personnel’ who the president mentions in his tribute to the ‘unsung heroes’ of the pandemic.

Over the course of the national lockdown, these personnel have ensured that social distance is maintained, masks are worn, and hands are sanitised; that alcohol is not sold outside the legal hours, that unapproved travellers do not cross provincial borders, and that the night-time curfew is respected. What with the rhetoric of ‘combat’ and ‘invisible enemies’; of ‘national emergency’ and a ‘life and death war’ – this securitisation of care is precedent. By articulating both social and physical ills in the language of war, humanitarian questions – even questions of peace – become a matter of security.

While performing their ‘duty to protect,’ police and military officials could not fight a virus. Instead, they made high-density, and therefore poorer, areas their targets. Whether these neighbourhoods had been prioritised because they were especially *under threat* during a pandemic, or because they were deemed especially *threatening* to those beyond their boundaries, was not clear. Instead, pandemic turned people into potential contaminants; easy targets; criminalised walkers. In Hillbrow, police enforced lockdown with sjamboks and rubber bullets. Within the first two months of lockdown, reports of police violence had doubled (Reddy and Allison 2020). By June, 230,000 people had been arrested for lockdown violations (Trippe 2020). Filtered through a security lens, the language of care justified the rounding-up of homeless people, the removal and relocation of refugees, and the eviction of people from informal settlements; with clear implications about who and what matters.

State vs market care

Existing alongside, and sometimes in tension with, calls for public responsibility and resilience; has been the mass distribution of Covid-19 ‘state relief’, which has served to extend the country’s expansive social security programme. Not only have child support grants been topped-up, offering much-needed care for carers, but a special Covid-19 relief grant has also been introduced for those without income or pre-existing social support. Government further announced that it would be ‘providing shelter

to people who were homeless', rolling out food parcels, and 'continuing to deliver water to areas that do not have water'.

Here, responsibility for care resides with the state, with care defined as the provision of basic welfare to which all are rightfully entitled.

Throughout lockdown, activists have mobilised this rights-based discourse to assert citizens' right to care and make claims on government. Pressure was put on the government to resume the National School Nutrition Programme (upon which 9-million learners depend) regardless of school closures. Similarly, with significant job losses in the Early Childhood Development (ECD) sector and only 13 per cent ECD attendance from July to mid-August 2020 (Wills et al 2020), civil society groups have petitioned to salvage the right to care for young children.

South African welfare distribution has been a key site of contestation around care, and responsibilities for caring. Despite robust evidence to the contrary (Davis et al 2016, Devereux 2011), critics of welfare argue that state grants promote dependency and erode work ethic. A more caring response, they argue, is to promote self-reliance and hard work. This rests, of course, on a foundational neoliberal assumption: that the market knows best. Here, financial markets are tasked with what governments once did by central planning: that is optimally distributing resources to meet people's wants and needs.

Despite its expansiveness, the shape of the South African social welfare system has also rested on this assumption, providing grants only to those deemed unable to work. Pensioners, children, and the disabled are provided for, classed as 'deserving poor'. Meanwhile, there is no direct payment to working-age, unemployed adults, despite deepening structural unemployment, and the rise of precarious work. Instead, the market continues to be treated as a viable instrument to deliver care.

The introduction of the special Covid-19 grant has been path-breaking in this respect. Although government insists the special grant is only a temporary crisis measure, the exclusion of millions of South Africans from the labour market long preceded Covid-19. Indeed, relying on the wage economy to care for South Africans has been unrealistic for some time.

Guaranteed income security for all would not only offer a more caring response to this reality, it would also recognise the unpaid (care) labour on which much of the formal economy depends.

Towards a post-Covid fantasy

The special Covid-19 grant offers one example of a promising rupture with the status quo: an approach to care we might seek to sustain long after this newly-defined (though in fact long-standing) ‘crisis’ subsides.

What would it look like if we were to imaginatively extend these lessons about care and caring, and write an alternative? In this final section of the paper, I attempt just that.

Unsung heroes. That’s what they called us in the First Pandemic Year – unsung. But Desiree can already hear the singing as the rows of *Care Force* workers pass by her house. Her son is at the window, puffing out his chest, showing off his *Care Force* T-shirt.

Minutes later, the two of them join the crowd, following the procession through the local park. The First Pandemic Year had prompted a rediscovery of these public spaces. Families with nowhere else to socialise, and a desperate need to be outside, repopulated parks for picnics, exercise, and play. The same park now boasts a vegetable garden, managed by the revived street committee. There are formalised play groups for children, with *Care Force* representatives offering reading clubs and cognitive games. At the edge of the park, Desiree stops to buy sandwiches.

Who knew how long the ceremony would last? They might as well go prepared.

With government having created more space for small-scale food retailers, these stalls were now everywhere. And thank goodness. For Desiree, whose *Care Force* internship had meant she was regularly on the go, convenient fresh food was a godsend.

Today, she would be inducted as a fully-fledged Caregiver. The *Care Force* had many arms: the Health Workers, including doctors, nurses and caregivers; the Social Workers including counsellors, childminders, mediators, and psychologists; the Educators including teachers, mentors, and tutors; and the Community Workers including small-scale farmers and water practitioners. This multi-faceted force was a reflection of a new approach to and of care: one which was not only about surveying health risks, but also about upholding the wider ecology of care, which ultimately determined vulnerability to illness.

Desiree's son clutched her hand and gestured towards a group of uniformed social workers, walking happily alongside them. 'That'll be me one day,' he said. Desiree knew her son would likely have chosen a new 'dream-job' by tomorrow. But nevertheless, she was proud. The local papers reported growing numbers of young people entering *Care Force*. Despite all the fears surrounding the '4th Industrial Revolution', there was one essential role for which technology was no substitute: meaningful care.

Only a decade or two earlier, Desiree's son might have been among those that dreamed of being a police officer. These days, the police had been drastically reduced, with many of their roles overtaken or shared by *Care Force*. With *Care Force* now running expanded mental health, recreation, and homelessness programmes, crime rates had declined dramatically; while cases of domestic abuse, drug addiction, and juvenile crime, were automatically deferred to *Care Force*.

The annual *Care Force* induction ceremony included a mix of all categories of workers that would be posted to Desiree's neighbourhood. It was a day of much fanfare, since the *Care Force* were held in high esteem. The First Pandemic Year had made plain whose work was essential, and how regularly this work was undervalued. Back then, the country watched on in horror as its overspent and undervalued essential workers took on unimaginable risks and burdens. It marked the end of an era, and the start of a new one, in which all members of the *Care Force* would be permanently employed, properly remunerated, and supported.

Care Force members were also integrated into key decision-making bodies at both national and local level, informing contextually-specific, justice-oriented care policy. In the new language, every citizen understood themselves as both a giver and receiver of care – roles that were mutually constitutive.

Desiree followed as the procession passed her old school. The school had changed significantly since Desiree was a student. Now it was not only a place of teaching and learning, but also offered a range of other public goods. School nutrition programmes had been expanded, operating both during and outside the teaching calendar. Every school was equipped with a small team of *Care Force* workers, offering health services, childcare, and family counselling. On grant distribution days, the grounds of the school became one of the many service points to collect basic income. It no longer mattered whether or not one could find work, no-one went hungry, and social inclusion no longer rested on the 'hidden hand' of the market.

By now, the soon-to-be-inducted *Care Force* had filed into the town hall, along with their friends, family, colleagues and neighbours. The room hushed – a speaker rose to the podium:

Good morning friends and family, and welcome.

Much has changed since the First Pandemic Year. We, as government, have been compelled to listen, and appreciate, that much of our care response had lost sight of caring. One day, your children will ask you how this change happened? Your answer is this: we had to act as though a different world were possible. We had to act it every day, until it stopped being pretend.

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