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*Travelling HIV treatment policies and their imprints on the local healthcare settings in Swaziland*

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## **CHAPTER 8**

### **Epilogue: Reflecting on Fieldwork**

Research is enquiry into something outside of oneself. Through research, one seeks answers that one cannot get through introspection. Davies (2008) articulates that we investigate things we are connected to somehow, which implies that researchers become part of what they are researching. Therefore, it is not irrelevant to question whether the text is a residue of the researcher's influence on the research process. This makes reflexivity important especially for ethnographic research because of the close connection the researcher shares with the research setting as the ethnographer becomes deeply embedded in the lives of those studied. Reflexivity refers to contemplating the ways in which the products of research are affected by the research process. It encompasses the researcher's initial selection of topic, choice of study site, field relations, interpretive practices to produce texts, and final reporting of results (Foley, 2002). Reflexivity helps the researcher ponder their own experience, through a constant mirroring of self in the research with the socially constructed self (Foley, 2002). The self becomes a multiply constructed image that is constantly changing. Van der Geest (2002) attests that when he conducted research about the elderly in Ghana he had to think about his own aging. The process of self–other exploration in fieldwork is critical for ethnographers, if we are to produce more insightful studies and show awareness of our limits as interpreters of the field.

The need to have a reflection chapter in this thesis is necessitated by my desire as a new ethnographer to refine my reflexive skills and follow in the footsteps of Malinowski, Sontag, and Geertz in my quest to produce astute scholarship. This thesis depends heavily on participant observation, which Davies (2008, p. 68) calls the 'hallmark of anthropology and rite of passage to become a real anthropologist', and the only sure claim to verify 'we really have been there'. Lastly, as I conducted fieldwork in my native country, it is important for me to reflect on the degree to which being native has influenced the research.

I easily fit the category of ‘native anthropologist’ as coined by Narayan (1993). Narayan conducted ethnographic research in the village where he grew up. Yet sometimes he was viewed or felt like a stranger. I include this chapter not to assure veracity of my interpretations, but to identify my position in the overall research process and bring the reader into my moments of vulnerability, despair, conflict, and concord as I faced different encounters in the field as a result of my nativity. My reflexivity chronicle weaves three topical issues: native claims, shifting identities and emotions in the field, and my shifting role during fieldwork.

#### Native authority claims

The descriptions and quotes in this thesis resonate so much with me that the experiences of the research subjects could have been those of my mother, sister, uncle, neighbour, or friend. This is in stark contrast to the assertion by Butt (2002) that anthropologists write about suffering strangers, the poor and powerless, whose stories are produced for international consumption. Anthropologists do sometimes write about people they are not connected to and may never see again, but this is not so in my case. Some activist anthropologists collect data, sympathize with sufferers, and thereafter tell the tales for international consumption, and probably end there. In my case, my native instinct was a constant presence; it influenced how I interpreted data and how I made sense of what I saw during fieldwork. From the outset, I hoped my study would change paradigms that would lead to transformation of lives and better treatment services for those who need them. It was not just solely about conducting research to get a PhD but to use this opportunity to flag issues and experiences to bring about transformation because I shared affinities with those I studied. Improved quality of care could benefit a close friend, a relative even, so I had somewhat a sense of duty.

Swaziland is generally described as homogenous; it is a small country of people with one language and one clan, who are ruled by a king and share many commonalities. That said, I have observed that there are actually many things that make us a heterogeneous society: different socialization, religions, education levels, and classes; whether one lives in an urban or rural areas; and how connected children are to their parents. People have different work experiences, whether in white-collar or blue-collar jobs, in prestigious organizations or mediocre ones, and with opportunities to travel or not. Businesspeople may work in a big business or small enterprise. We are heterogeneous in many other ways: whether one's children attend public or private schools, and if they are multicultural schools or not; where one buys food; if one owns or rents one's home, and if the home is on communal or private property; and whether one's car is new, second-hand, local or imported.

This diversity is not distinct to my society but exists elsewhere too. Nativity undoubtedly at times gives legitimacy and can provide greater authority and perspective on certain issues compared to non-natives. However, nativity is not supreme. Despite being a native there were some issues I could not fully understand. A case in point, my more than 20 months of exposure and immersion into the worlds of expert clients – witnessing their diligence on the job despite very challenging circumstances, and how they endured prejudices and exploitation in the line of duty – reminded me of the daily folklore told to me as a child by my ancestors, who lived through the apartheid atrocities and were victims of an exploitative system. This largely was my interpretative framework to explain the circumstances that expert clients were in. I carried this framework with me throughout fieldwork, until at the analysis stage I realized there were other explanations for the status of expert clients within the public health system other than just capitalist tendencies. I removed emotions, and allowed myself to be comprehensive in approach and extend my perception to other factors and the historical context for engaging PLHIV in delivery of care. Davies (2008) argues that

if data is presented as is and emotions removed in analysis it helps the anthropologist to see things in a different perspective, and it is not so much about being a native or an outsider. This is what characterizes classical anthropological texts, and I too came to this realization so it rings true to me.

Though the discourse of native claims remains relevant, there remain many things that separate us as people in the same society. For example, though ethnography as a research methodology deeply informed me regarding what it means to live with HIV, the experience of surviving a powerful and chronic disease will forever remain foreign to me and superficial as I do not live with the disease. There are many dynamics that make me alien to the experiences of those infected by HIV because some things need to be experienced bodily for one to fully understand it.

### Shifting identities and emotions in the field

Whether you research yourself or another, one experiences shifting identities because education, gender, sexual orientation, class, race or religion may at different times outweigh the cultural identity we associate with insider status (Narayan, 1993; Patel, 1998). I embraced multiple identities during my fieldwork at different points: a researcher, a friend, a confidante, a health worker. At times being a daughter of the soil, showing *Ubuntu*<sup>11</sup> took precedence, as well as being a mother or a wife and identifying with circumstances of my interlocutors. I am sure by some I was perceived as an outright mean health worker, yet by others as a compassionate counsellor. Although I was a PhD candidate, there were times during fieldwork when I had to submit to clinic staff whose highest qualification level was

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<sup>11</sup> Showing Ubuntu means being empathetic, sharing in another's suffering, and extending a helping hand.

below that of an undergraduate, and I allowed myself to be overworked, bossed around, and stifled when I was a trainee counsellor.

I want to illustrate my experience with the shifting emotions in the field by contrasting my roles as a counsellor and as a researcher. As part of the HTC internship, I was attached to three clinics for one week each where I provided counselling services to more than 80 patients in total. I can narrate my emotional voyage from the first day in the practicum and on the last day of the practicum and classify into four phases: diligence, empathy, complacency, and transactional. Though this was my personal journey during the practicum, I observed that other counsellors experienced a similar pattern. The beginning of the practicum was characterized by *diligence*. I was empowered and eager to help HIV-positive patients understand the meaning of the diagnosis and support them to make the right decision to manage the disease. However, this phase did not last a very long time because the circumstances in reality were different: infrastructure shortages impeded confidential counselling, and high-patient volumes in the clinics took precedence over giving patients enough time they need for counselling. *Empathy*: at this point it was possible to show genuine caring and concern for the client and identify with their predicament. Exploring options to support patients to find solutions to their challenges was still priority for the counsellor. In the *complacency* phase, unpleasant realities of the job, such as the small pay given for working as a volunteer and the pressure of the job began to dampen my spirit. What I observed about the counsellors at this point was that they began to understand the politics and intricacies of the job and empathy was eroded slowly. During the *transactional* phase, the job was done to deliver results, and the counsellors do it because they need a livelihood. The motivation of the counsellors was at rock bottom and the counselling was standardized and formulaic, rather than personalized. In my case, I had to endure this phase because I needed the data for my study. I realized that it was at this point that counsellors used

disciplining mechanisms when providing care services to clients. This experience helped me understand the process through which counsellors' enthusiasm and motivation wanes.

### Shifting roles

Throughout the fieldwork period, I wore different hats. Many times, I had to be a health broker, providing answers to questions that were supposed to be asked to counsellors and nurses during a counselling session. I had to dispel fears, correct wrong notions about ART, and intervene in family situations. My HTC counselling experience came handy as patients needed accurate information and support to develop skills to navigate obstacles that were stopping them from taking ART. Participants occasionally called to ask for help as they encountered challenges in the clinics or with their treatment. Sometimes I had to answer questions related to the side effects of ART. Other needed to be advised to return to the clinic soon instead of waiting for a later appointment; some patients were not aware they could do that, and such simple advice proved immensely valuable.

As Narayan (1993) narrated, as a native anthropologist, there were moments to be involved and moments to detach myself, times to step in and out of different roles, as I was assimilated into the lives of those I studied. Sometimes, it was impossible to disconnect from my socialization or to ignore the plight of others when I could intervene and make a difference in someone's life. Going the extra mile to provide intense counselling to my research subjects and the visits and food I brought along were all due to the emotions roused when I became familiar with their circumstances, just as if they were a friend or relative. One research subject stands out in my memory: a young married woman in her mid-20s whom I connected with throughout my fieldwork. She could not start treatment because of issues in her marriage. I provided counselling to her numerous times and to her husband. It became a personal project. Her husband eventually agreed to test for HIV and started



treatment in good time, and this made it easy for the wife to start treatment too and save their second child from vertical HIV transmission since the first child got HIV because the wife feared being ostracized if she took ART. I did it with zest because I was empathetic towards the young family as the wife shared intimate details of her life. Looking back, I realize that my understanding of the vulnerabilities associated with being a young, married, and dependent Swazi wife made me be connected with her as I was also a young Swazi wife.