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FACULTY OF HUMANITIES AND SOCIAL SCIENCES

School of Social Science: Culture Cluster

**Exploring the experiences and coping practices of home-based
caregivers treating persons diagnosed with mental illness in Clermont
Township, KwaZulu-Natal.**

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DECLARATION

I, Londiwe Jabulile Simelane, declare that this dissertation is my own original work and is written in my own words. All sources used, whether published or unpublished, have been properly acknowledged within the text, and a complete list of references has been provided.

I further declare that this dissertation has not been submitted to any other institution for the purposes of obtaining an academic qualification.

Signed: _____



Date: _____

Supervisor

Signed: _____



Date: 27 March 2026

DEDICATION

This dissertation is dedicated to my late grandparents, Mr and Mrs Makhanya, whose home was my first sanctuary, a source of comfort, and a defining influence. They nurtured me with warmth, instilled discipline, infused humour, imparted wisdom, and radiated an unwavering love that shaped the woman I am today. The loss of their presence created a void in my life, yet their influence continues to guide my steps in ways that words cannot fully express. I long for their presence to celebrate this moment with me, to share in my triumph, and to proclaim, “That is our daughter.” Every achievement, including this one, bears the imprint of their love and the wisdom they bestowed. Their legacy lives on within me, and I trust that this work will bring them the same pride they once instilled in me, reminding me of the love, support, and belief they entrusted to me.

This work is dedicated to everyone affected by mental illness, whether personally or through caring for a loved one. To the caregivers who silently carry emotional, physical, and spiritual labour: your strength is seen. To those living with mental health challenges, know your story matters. You are not alone, and your humanity is worthy of dignity and understanding. May these pages raise awareness, compassion, and hope.

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Usebenzile MaSimelane, Magutshwa, Mpembe kaLokothwayo, Nkomo zidlekhaya ngoba ziswele abelusi.

Ngiyazidla ngawe.

ABSTRACT

This study explored the experiences and coping strategies of home-based caregivers in Clermont Township, KwaZulu-Natal, who care for relatives living with mental illness. Guided by an interpretivist phenomenological design, the research examined how caregivers construct meaning around their caregiving roles. Data were generated through in-depth interviews, participant observations, and group discussions with 20 caregivers, and analysed inductively using thematic analysis. The study was informed by Social Constructionism, Feminist Theory, Social Identity Theory, and medical anthropology, which together helped illuminate how caregiving is shaped by cultural norms, gendered labour, relational identity, and local interpretations of illness. Caregivers reported exhaustion, fear, stigma, strained relationships, and disruptions to household roles. Despite these challenges, they demonstrated resilience through prayer and spiritual rituals, peer support, acceptance, distraction, routinised care practices, and the combined use of biomedical and traditional healing systems. Structural constraints such as unemployment, gendered expectations, limited social support, and fragmented mental healthcare intensified caregiver burden. Yet many caregivers also described pride, identity reinforcement, and personal growth arising from their caregiving responsibilities. This study contributes to the understanding of community-based mental health care in South Africa by foregrounding the often-invisible labour of township caregivers. It highlights the need for culturally responsive psychosocial support, improved integration between formal and informal care systems, caregiver training, and policies that recognise and support home-based mental health caregiving.

Key words: mental illness, home-based care givers, coping strategies, care giver burden

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CHAPTER 1: Introduction and background

1.1 Background and Significance of the Study

Mental illness is a major public health issue in South Africa, with one in six adults affected by common mental disorders like anxiety and depression (SADAG, 2023). Despite this, the mental health system is severely underfunded, especially in rural areas and townships. A shortage of trained mental health professionals and limited access to formal treatment facilities in under-resourced communities has resulted in increased reliance on family members and informal community networks to provide long-term care and supervision for persons living with mental illness (Brooke-Sumner et al., 2021; Sorsdahl et al., 2022). This reflects systemic issues and societal expectations of familial caregiving.

Mental illness, as defined in biomedical frameworks, is a diagnosable condition that significantly impairs thinking, emotional regulation, or behaviour. Disorders like schizophrenia, bipolar disorder, major depression, and anxiety are classified in diagnostic manuals like the DSM-5-TR and ICD-11 (World Health Organisation, 2022). Diagnosis involves clinical interviews, psychological assessments, mental status examinations, and caregiver input to identify and categorise symptoms (First et al., 2018).

Medical anthropology challenges the notion of mental illness as purely biological or psychological, framing it as a socially constructed and culturally embedded experience. Anthropological approaches emphasise that cultural meaning, language, and social relationships shape how mental distress is expressed, understood, and treated. Mental illness in many African contexts is frequently interpreted through spiritual, ancestral or supernatural frameworks, reflecting pluralistic belief systems that coexist with biomedical understandings of mental health (Ae-Ngibise et al., 2020; Campbell & Burgess, 2022).

A dual lens biomedical and cultural approach is essential for understanding how home-based caregivers navigate complex pluralistic health environments in settings like Townships.

Medical anthropology offers a critical framework for comprehending mental illness as a phenomenon influenced by cultural norms, local belief systems, and structural inequalities (Kohrt & Mendenhall, 2021). It emphasises the importance of community-specific explanatory models in understanding illness, describing mental distress, identifying causes, and determining appropriate healing practices. Across the Global South, mental distress is frequently expressed through culturally specific idioms of distress, such as spiritual possession or somatic symptoms, which may not correspond to Western diagnostic categories (Galvin et al., 2023). These insights highlight the need for culturally sensitive and socially responsive mental health interventions (White & Jain, 2022).

This study, using a medical anthropology lens, explores the realities of home-based caregivers in Clermont Township. It highlights how they navigate biomedical, spiritual, and traditional healing systems. Home-based caregivers are not passive recipients of medical advice but active agents in complex cultural and structural contexts that shape mental health care.

The diagnosis of mental illness is a multifaceted process. Biomedical approaches employ standardised frameworks such as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) (American Psychiatric Association, 2022) and the International Classification of Diseases, Eleventh Revision (ICD-11) (World Health Organisation, 2021) to categorise disorders based on clinical symptoms, severity, and functional impairment. Clinicians conduct comprehensive evaluations, encompassing medical histories, psychiatric interviews, and psychological assessments, often incorporating observations from home-based caregivers (First et al., 2018). Differential

diagnosis is crucial to ensure that symptoms are not attributable to other medical or substance-related conditions.

From a medical anthropology perspective, diagnosis goes beyond biomedical assessments to include sociocultural interpretations of distress. In South African communities, mental illness is often seen as a spiritual or social imbalance caused by ancestral displeasure, witchcraft, or cultural violations (Ngcobo & Pillay, 2022; Sor Dahl et al., 2023). These interpretations shape how families describe symptoms, determine causes, and seek healing.

Traditional healers like izangoma and inyanga play a key role in local healthcare systems. They use divination, ancestral communication, and symbolic interpretation to identify illnesses rooted in cosmology or morality (Ngubane, 2022; Niehaus, 2020). Treatments often include herbal medicines, cleansing rituals, and spiritual counselling, which are considered culturally valid and legitimate forms of care (Gureje et al., 2020; Mkhize & Kometsi, 2021). Medical anthropology recognises these as valid health epistemologies, providing insights into how communities construct meaning around mental illness.

Pluralistic care combines biomedical services like pharmacology, psychotherapy, and rehabilitation with traditional healing practices. The World Health Organisation (2023) advocates for this approach, aligning with anthropological calls for culturally adapted, decolonised mental health interventions (Kohrt et al., 2020). It's crucial in low-resource settings with limited formal psychiatric care or culturally mismatched illness understanding.

Home-based caregivers play a critical role in supporting persons living with mental illness within under-resourced South African communities. Often, home-based caregivers assume the primary responsibility for daily supervision, emotional support and treatment adherence in contexts characterised by limited

access to formal mental health services (Sorsdahl et al., 2022; Brooke-Sumner et al., 2021).

Home-based caregiving is a socially embedded process influenced by cultural expectations of kinship, communal responsibility, and health beliefs, as seen in medical anthropology (Campbell et al., 2020). Home-based caregivers in South Africa often act as cultural brokers, bridging the gap between biomedical professionals, traditional healers, and community support systems (Teng et al., 2021). In contrast to formalised and professionalised caregiving in high-income Western contexts, South African caregiving is largely informal, unpaid, and deeply rooted in family structures and cultural values (Kleinman, 2020; Narayan & Mattingly, 2021).

1.2. Clermont Township: Contextual Factors Shaping Caregiving

Historically, South Africa's townships, created under apartheid policies of racial segregation, have been underdeveloped residential areas. These areas are still characterised by poverty, high population density, inadequate infrastructure, and limited access to healthcare and social services (Seekings, 2020). Clermont Township, situated on the outskirts of Durban, holds a unique history as one of the few townships where Black South Africans were historically permitted to own property. Despite this, it continues to grapple with systemic marginalisation, inadequate mental health service provision, and high levels of unemployment and social inequality.

Home-based caregiving is a crucial coping mechanism for families with mentally ill members. Home-based caregivers in Clermont endure significant emotional, physical, and financial strain, frequently providing long-term care with minimal training, support, or respite (Madlala et al., 2022). Stigma and social isolation exacerbate their burden, reflecting global patterns observed in other low- and middle-income countries, including India and Brazil (Sodi et al., 2021; de Souza

et al., 2023). Caregiving is complicated by the coexistence of biomedical and traditional healing systems, as families must navigate conflicting explanations of illness (Maboe & Mokoena, 2020).

Caregiving globally is predominantly female, with women assuming primary home-based caregiving roles in formal and informal settings (Lilly, Laporte & Coyte, 2020; Chigangaidze et al., 2023). In South Africa, mothers, grandmothers, or sisters often provide home-based care due to cultural norms associating femininity with nurturing and domestic labour (Mkhonto & Hanssen, 2021). These gendered expectations, coupled with structural inequalities and unpaid labour, lead to emotional exhaustion, depression, and financial hardship for women caregivers (Craig et al., 2022; Rapiya et al., 2025).

Home-based caregiving is a socially constructed and morally charged role, reflecting broader societal beliefs about gender, kinship, and obligation (Narayan & Mattingly, 2022). Understanding these gendered dimensions is crucial for developing equitable, culturally sensitive mental health interventions that address women's disproportionate caregiving burden in Clermont Township.

1.3. Research Problem Statement, Motivation, Aim, and Objectives

Problem Statement

Mental illness is a major public health concern in South Africa, contributing significantly to the national burden of disease and disability (Nguse & Wassenaar, 2021; Craig et al., 2020). Despite progressive mental health policies, widespread implementation gaps, and an under-resourced public health system mean many individuals with mental illness remain underserved, especially in low-income and peri-urban areas like Clermont Township in KwaZulu-Natal (Department of Health, 2023; Clarke, 2022).

Within this context, home-based caregivers play a crucial yet often overlooked role in maintaining mental health care. These caregivers, predominantly women, provide long-term, often lifelong care to relatives or community members diagnosed with mental illness. They face challenging socio-economic conditions, limited access to training, scarce psychosocial support, and pervasive cultural stigma associated with mental health disorders (Madlala et al., 2022; Ndlovu & Pillay, 2023). Despite their central role in care continuity, the lived experiences and coping mechanisms of these home-based caregivers remain significantly under-researched in South Africa, particularly in township settings where formal mental health infrastructure is inadequate or nonexistent.

Caregiving experiences differ globally due to socio-economic, cultural, and policy factors. In high-income countries like the US and UK, home-based caregivers often receive structured support, including financial aid, trained professionals, and respite care (Reinhard et al., 2023; Carers UK, 2021). In middle-income countries like India, community mental health programs offer psychoeducation and peer support to reduce caregiver burden (Mathias et al., 2022). However, in South Africa, systemic barriers, gendered expectations, and diverse illness models (biomedical, spiritual, and traditional) create unique caregiving challenges that lack culturally informed understanding.

This study explores the realities of home-based caregivers in Clermont Township through a medical anthropology framework. By examining their experiences and coping practices, it aims to illuminate how culture, gender norms, socio-economic constraints, and plural health systems shape informal caregiving in a township context.

Motivation for the Study

This research's motivation stems from three interconnected factors.

First, a persistent gap exists in the literature and policy regarding informal mental health care in South Africa, particularly in peri-urban townships where state services are underfunded and overburdened. While formal mental health research frequently concentrates on institutional care or affluent settings (Reinhard et al., 2023; Carers UK, 2021), knowledge is scarce regarding the realities of home-based caregivers who provide mental health care in resource-constrained settings.

Second, Caregiving is not merely a technical act but a socially embedded role, shaped by cultural meanings of illness, kinship obligations, and gendered divisions of labour. A medical anthropology perspective provides a critical means of understanding how home-based caregivers interpret mental illness, negotiate between biomedical and traditional healing systems, and make sense of their responsibilities within broader socio-cultural frameworks (Kohrt & Mendenhall, 2021). Without culturally sensitive analysis, policy interventions risk overlooking the lived realities of home-based caregivers and perpetuating systemic neglect.

Third, Contextual mental health interventions that value home-based caregivers are urgently needed. This research highlights their challenges and coping strategies to inform inclusive, gender-sensitive, and culturally appropriate mental health policies in South Africa and other low-resource settings.

Aim of the Study

This study aims to explore and critically analyse the experiences, coping practices, and support needs of home-based caregivers in Clermont Township, KwaZulu-Natal, using a medical anthropology lens to understand caregiving as a social and cultural practice.

Research Objectives

The study is guided by the following specific objectives:

1. To describe the socio-demographic profile of home-based caregivers providing mental health care in Clermont Township.
2. To explore the day-to-day caregiving experiences and challenges faced by these home-based caregivers.
3. To identify and analyse coping strategies, Emotional, behavioural, cultural, and spiritual employed by home-based caregivers in managing the stress and burden of care.
4. To examine the role and accessibility of formal and informal support systems available to home-based caregivers in Clermont Township.
5. To investigate the influence of gender dynamics on caregiving roles, responsibilities, and coping approaches.
6. To provide evidence-based recommendations for improving home-based caregiver support in community-based mental health services in KwaZulu-Natal, informed by home-based caregivers' lived experiences and cultural contexts.

Key Research Questions

In line with the aim and objectives, this study seeks to answer the following questions:

- What are the socio-demographic characteristics of home-based caregivers in Clermont Township?
- How do home-based caregivers experience and make sense of their caregiving roles within the local cultural context?
- What coping strategies do home-based caregivers adopt to manage the emotional, physical, and financial burden of care?

- What formal and informal support systems are accessible to home-based caregivers, and how effective are they perceived to be?
- How do gendered expectations shape home-based caregiving responsibilities and coping mechanisms?
- How can community-based mental health policies and programmes better support home-based caregivers in low-resource township settings?

1.4. Operational Definitions of Key Concepts

This section defines key concepts in this study to ensure clarity and coherence. Each term is framed within a medical anthropology lens, highlighting its biomedical, social, and cultural dimensions relevant to home-based caregiving in Clermont Township.

Home-Based Caregivers

Home-based caregivers, often family or community members, provide long-term care to people with severe mental illness in their homes or communities. They lack formal mental health training but offer physical assistance, emotional support, supervision, and advocacy due to kinship, cultural expectations, and limited access to institutional care (Vukeya, 2022; Nguse & Wassenaar, 2021). Medical anthropology views its role as a socially embedded practice, influenced by gender norms, communal ethics, and socio-economic constraints, rather than a purely voluntary or individual choice.

Mental Illness

In this study, mental illness is defined as clinically recognised psychiatric disorders under the DSM-5 and ICD-11, including schizophrenia, bipolar disorder, major depressive disorder, and generalised anxiety disorder (Raphalalani et al., 2021). Mental illness, from a medical anthropology

perspective, is both a biomedical category and a culturally mediated experience. Symptoms, causes, and treatments are interpreted through local belief systems, spirituality, and social relationships.

Mental Health

Mental health is a state of psychological, emotional, and social well-being that allows individuals to cope with life's challenges, form meaningful relationships, and participate in community life (WHO, 2020). This study examines the mental health aspect of well-being, acknowledging that cultural factors like spiritual balance, moral order, and social harmony influence it, especially in African township settings (Kohrt & Pedersen, 2021).

Mental Health Services

Mental health services are provided by public hospitals, primary healthcare clinics, NGOs, and community-based initiatives, and include medical, psychological, and rehabilitative interventions. In South Africa, access to these services is uneven, with peri-urban townships like Clermont facing shortages of professionals, fragmented referral systems, and cultural differences between biomedical care and local illness explanations.

Mental Health Policy

Mental health policy, formal legislative and strategic frameworks, guides mental healthcare delivery, promotes human rights, and ensures community-based treatment (RSA, 2002; Nguse & Wassenaar, 2021). Policies like the National Mental Health Policy Framework and Strategic Plan aim to deinstitutionalise care and strengthen community support, but implementation gaps persist, leaving home-based caregivers with minimal support.

Social Support

Social support is emotional, informational, and practical assistance from family, neighbours, religious groups, traditional healers, and community networks (Silaule, Adams & Nkosi, 2024). Medical anthropology views social support as a collectivist ethic of care (ubuntu), but stigma, poverty, and gendered expectations can fragment it, hindering home-based caregivers' ability to seek or sustain help.

Coping Mechanisms

Home-based caregivers use conscious or unconscious strategies to manage stressors in long-term caregiving. These include adaptive approaches (problem-solving, prayer, community reliance) and maladaptive responses (withdrawal, denial, substance use) (Gamieldien et al., 2023). Coping in Clermont is deeply rooted in spirituality, traditional healing, and collective resilience, especially when medical care is scarce.

Resilience

Resilience is the ability to maintain mental and emotional well-being despite chronic home-based caregiving stress, stigma, and socio-economic hardship (Crossman, 2020; Silaule et al., 2024). Resilience, as understood in medical anthropology, is a socially and culturally mediated process arising from collective coping, faith-based resources, and familial solidarity, rather than individual traits.

1.5. Structure of the Dissertation

This dissertation is structured into seven interrelated chapters, each contributing to a comprehensive comprehension of the experiences, coping strategies, and support requirements of home-based caregivers of individuals diagnosed with mental illness residing in Clermont Township, KwaZulu-Natal.

- Chapter 1, Introduction. Presents the study context, research problem, aim, objectives, motivation, theoretical framework, and key concept definitions, concluding with an outline of the dissertation structure
- Chapter 2, Literature review. This chapter critically examines existing scholarship on mental illness, caregiving, stigma, coping strategies, and mental health support systems in South Africa and globally, contextualised through medical anthropology and the theoretical frameworks guiding the study.
- Chapter 3, Research Methodology. This chapter outlines the qualitative, phenomenological research design, sampling strategy, data collection, ethical considerations, and methods for ensuring trustworthiness of findings.
- Chapter 4, Understanding Mental Illness. This chapter discusses the participants' understanding of mental illness and their role as home-based caregivers.
- Chapter 5, Home-Based Caregivers' Experiences of Mental Illness. This chapter discusses four themes, namely socio-economic and structural challenges, the gendered aspects of caregiving, stigma and social isolation, and relationships with healthcare professionals. It provides an overview of the day-to-day experiences of caregivers.
- Chapter 6, Home-Based Caregivers' Coping Mechanisms for Mental Illness. This chapter explores the coping mechanisms employed by caregivers in an attempt to deal with their everyday challenges. It engages four thematic frameworks: adaptive coping strategies such as prayer, routines, peer support, and acceptance; maladaptive strategies including withdrawal, frustration, and overmedication; the role of networks and

support systems in mitigating strain; and cultural and gendered influences that shape the decisions made by home-based caregivers.

Chapter 7, Summary, Conclusions, and Recommendations. This chapter synthesises the study's findings, draws contextually grounded conclusions, and provides recommendations for policy, practice, and further research to strengthen support for home-based caregivers in township settings.

Chapter Two: Literature Review

2.1 Introduction

The literature on home-based caregiving for individuals diagnosed with mental illness reveals a complex, often overlooked dimension of global mental healthcare systems. While much academic focus has been placed on patients, treatment modalities, and psychiatric outcomes, the lived experiences of home-based caregivers, particularly those operating informally within communities, remain underrepresented, especially in low-resource settings such as townships in South Africa. This chapter critically reviews relevant literature through the lens of medical anthropology, which views illness and caregiving not merely as clinical phenomena but as culturally and socially embedded processes (Kirmayer & Pedersen, 2021). In many African contexts, including Clermont Township in KwaZulu-Natal, mental illness is interpreted through pluralistic frameworks that incorporate biomedical, spiritual, ancestral, and moral narratives (Monnapula-Mazabane & Petersen, 2023). Similarly, home-based caregiving is not simply a functional responsibility but is often understood as a gendered moral duty, particularly placed upon women. The literature reviewed in this chapter covers global, African, and South African contexts, with a particular emphasis on township dynamics and home-based caregiving. Through a synthesis of empirical studies, theoretical contributions, and home-based caregiver narratives, this chapter provides a foundation for understanding the complex interplay between illness, identity, culture, gender, and caregiving.

2.2 Socio-Cultural Understanding of Mental Illness

This section examines how mental illness is socially and culturally understood within African and global contexts, with a specific focus on Clermont Township, KwaZulu-Natal. Drawing from a medical anthropology lens, it explores how

communities interpret, label, and respond to mental illness through spiritual, ancestral, religious, and moral frameworks. The section also discusses plural health-seeking behaviours, the role of traditional and faith-based systems, and the implications of stigma, silence, and cultural blame on caregivers.

2.2.1 Medical Anthropology and the Cultural Framing of Mental Illness

Medical anthropology recognises that illness, including mental illness, is not only a biological disruption but also a culturally and socially constructed experience. According to Kleinman (2020 [reissue]), disease refers to the biological pathology, while illness refers to the subjective experience of symptoms as understood and expressed through cultural frameworks. This distinction is particularly salient in mental health, where interpretation is deeply shaped by spiritual beliefs, moral judgements, and social roles.

Kirmayer and Pedersen (2021) argue that psychiatric symptoms do not have a universal meaning, but are mediated through culture, language, and structural positioning. For example, hearing voices might be interpreted as psychosis in a Western psychiatric context, but in many African and Indigenous societies, it may be seen as spiritual communication. These divergent frameworks shape not only how symptoms are diagnosed, but also how they are responded to by families, communities, and health systems.

In African societies, including South Africa, mental illness is frequently understood through explanatory models that include ancestral dissatisfaction, witchcraft, spirit possession, and social conflict. Such interpretations are grounded in relational cosmologies that link individual suffering to disruptions in social, spiritual, and environmental harmony (Monnapula-Mazabane & Petersen, 2023). A person may be seen as mentally ill not because of internal dysfunction,

but due to unresolved family disputes, failure to perform ancestral rites, or being the target of jealousy or malevolent spiritual forces.

In Clermont Township, such beliefs are not abstract; they actively inform caregiving decisions. Home-based caregivers often alternate between public clinics and traditional healing systems, engaging in both biomedical and spiritual healing practices. This pluralistic approach is a rational response to multiple realities: not only the belief in supernatural causality, but also the ineffectiveness, unavailability, or culturally alienating nature of formal psychiatric services (Sibanyoni & Mhlongo, 2024).

Syncretism is where home-based caregivers draw from multiple systems to respond to what they perceive as layered forms of illness. This integrative approach is echoed in other African contexts. For example, in Uganda and Ghana, families often simultaneously consult psychiatric hospitals and faith healers, interpreting spiritual and biological explanations as complementary rather than contradictory (Sorsdahl et al., 2022).

Moreover, language plays a central role in cultural framing. In isiZulu, terms such as ukuphambana (to go mad), amafufunyana (spiritual possession or bewitchment), and ukuphuma emqondweni (losing one's mind) reflect morally and socially embedded conceptions of mental disruption. These expressions are often saturated with stigma, but they also offer symbolic insight into how distress is experienced and communicated within the community.

Home-based caregivers, often women, must navigate these symbolic frameworks while also contending with institutionalised biomedical models that may not acknowledge or accommodate their cultural knowledge. When home-based caregivers attempt to explain spiritual concerns at clinics, they are often met with dismissal or labelled as non-compliant. This creates a disconnect between lived

experience and clinical expectations, eroding trust and reinforcing stigma (Gibson et al., 2021).

There is an issue identified in medical anthropology: epistemic injustice, where certain forms of knowledge (e.g., spiritual or indigenous) are delegitimised in clinical encounters (Fricker, 2007; Bhugra et al., 2021). Such dismissal not only alienates home-based caregivers it also hinders effective mental health interventions.

Understanding mental illness as culturally framed has profound implications for how home-based caregiving is supported. Firstly, interventions that fail to incorporate local understandings of illness may be resisted or misunderstood. Secondly, the symbolic burden of home-based caregiving, where home-based caregivers are seen not only as carers but as morally responsible for the illness, adds layers of emotional and spiritual pressure.

In practice, a culturally competent mental health system in South Africa would:

- Train health workers in cultural humility and pluralistic engagement.
- Form partnerships with trusted traditional leaders and spiritual healers.
- Recognise and document indigenous explanatory models in assessments.
- Respect home-based caregivers' need for spiritual validation alongside clinical advice.

Finally, as Foucault's work on power and discourse suggests, medical institutions are not neutral. They are imbued with hierarchies that privilege Western epistemologies while silencing others. A medical anthropology approach insists on decolonising mental health care, recognising that communities like Clermont have their own healing languages, rituals, and models of care that must be engaged on equal terms (Mbembe, 2021).

2.2.2 Pluralistic Understandings and Care-Seeking

In many African contexts, including South Africa, mental illness is not understood through a single, unified explanatory model. Rather, families and caregivers often operate within a pluralistic health-seeking environment, drawing simultaneously from biomedical, traditional, and spiritual frameworks to make sense of illness and guide treatment (Kirmayer et al., 2021; Monnapula-Mazabane & Petersen, 2023). In Clermont Township, this pluralism is not an anomaly but a normative mode of care rooted in indigenous epistemologies, structural inequalities, and historical patterns of exclusion from formal healthcare systems.

The Rationality of Pluralism

Medical anthropologists argue that pluralistic care-seeking is a rational and adaptive response to the complex socio-spiritual terrain in which illness is situated. Home-based caregivers do not choose between science and tradition in a binary fashion; rather, they weave together multiple healing logics to produce what Janzen (1978) termed a “therapeutic itinerary.” This concept refers to the step-by-step journey individuals take across various medical systems to seek relief, not merely symptom relief, but spiritual, social, and emotional resolution. Kirmayer et al. (2021) describe explanatory model integration as the capacity to hold multiple, sometimes contradictory, beliefs about causality and treatment. Rather than evidence of confusion, this reveals cognitive flexibility and cultural competence among home-based caregivers who are tasked with navigating uncertain terrain.

Fieldwork in South African communities illustrates that many home-based caregivers use public mental health services to access medication while simultaneously consulting sangomas for traditional diagnoses and church leaders for spiritual deliverance. In a study by Monnapula-Mazabane and Petersen

(2023), home-based caregivers reported switching between psychiatric clinics and religious healing centres depending on whether they felt the condition was caused by amafufunyana (spirit possession), witchcraft, or biological imbalance. Similarly, a 2022 study by Nyame and Osei in Ghana showed that over 60% of families used both psychiatric medication and prayer camp interventions. This cross-continental parallel reinforces the idea that pluralism is a continental home-based caregiving strategy, shaped by both culture and necessity.

Placing the burden of care on home-based caregivers in South Africa without corresponding systemic support exacerbates the reliance on pluralistic strategies. Clinics in township areas like Clermont often suffer from:

- Medication stock-outs
- Understaffing
- Cultural insensitivity from mental health professionals
- Lack of counselling or emotional support
- Judgement of spiritual or traditional beliefs (Nguse & Wassenaar, 2021)

These gaps drive families towards systems that offer not just treatment but meaning, belonging, and community solidarity. At churches, for example, home-based caregivers find communal prayer, emotional validation, and a shared cosmology of healing. At the same time, inyangas provide symbolic rituals, diagnosis through divination, and culturally resonant explanations that are absent in psychiatric language.

This is particularly important in communities where the biomedical framework lacks cultural translation. For instance, clinical terms like “bipolar disorder” or “psychotic episode” do not exist in local languages. Instead, people speak of “losing one’s mind” (ukuphambana), being taken by spirits, or suffering a curse,

terms that reflect social and spiritual causation rather than purely neurochemical imbalance.

Pluralistic caregiving is not unique to South Africa. In Uganda, Whyte (2020) observed that home-based caregivers often toggle between hospitals and spiritual sites not because of superstition, but because both provide different types of relief. Similarly, in India, Das and Das (2020) found that home-based caregivers navigate between Ayurvedic medicine, spiritual rituals, and psychiatric care depending on financial access and cultural fit.

In Brazil, therapeutic residences that blend biomedical and psychosocial support, including spiritual guidance, have shown high success in improving patient and home-based caregiver wellbeing. These models suggest that pluralism need not be an obstacle to care, but rather a resource when thoughtfully integrated (Skeen et al., 2023).

Navigating pluralistic systems places an emotional and logistical burden on home-based caregivers. They are often the ones who coordinate appointments, source traditional remedies, pay church fees, manage side effects of psychiatric drugs, and evaluate whether a symptom is spiritual or medical in nature. This multi-system coordination reflects both their cultural embeddedness and structural vulnerability. This kind of emotional navigation is rarely recognised by health systems or policy documents, yet it is central to understanding the psychosocial ecology of home-based caregiving.

Several scholars advocate for collaborative models of care that include both biomedical and traditional actors. The WHO has begun to support community mental health initiatives that form partnerships between psychiatric nurses, church leaders, and traditional healers, a model piloted in Ghana and Kenya with encouraging outcomes (Bhugra et al., 2021; Skeen et al., 2023).

In South Africa, there have been calls to formalise such collaborations through:

- Joint training workshops
- Referral systems between clinics and faith-based centres
- Cross-disciplinary mental health education
- Policy inclusion of indigenous knowledge systems

This would validate pluralism as a strength, not a liability. Furthermore, it would affirm the agency of home-based caregivers, who are often the silent coordinators of these fragmented systems. Pluralistic care-seeking is not a reflection of confusion or rejection of medical knowledge, but an embodied strategy of survival, meaning-making, and spiritual care. For home-based caregivers in Clermont Township, pluralism represents a culturally grounded logic of care in which illness is not merely a medical problem but a relational, moral, and existential event. It also reflects the reality of systemic gaps in psychiatric services and the resilience of informal care networks.

From a medical anthropology perspective, responding to mental illness in such contexts requires a deep respect for local epistemologies and an ethics of listening to home-based caregivers who have become cultural navigators in a plural world of healing.

2.2.3 Stigma, Cultural Blame, and Secondary Marginalisation

While cultural frameworks can provide meaning and therapeutic pathways in the face of mental illness, they also have the potential to reinforce stigma, blame, and social exclusion. In many South African communities, including Clermont Township, mental illness is frequently understood not as a clinical diagnosis but as a moral or spiritual failure. Such framings place responsibility for the illness not only on the affected individual but also on home-based caregivers,

particularly women, who are seen as morally negligent or spiritually contaminated (Link & Phelan, 2021; Monnapula-Mazabane & Petersen, 2023).

This phenomenon is referred to as secondary stigma, a process whereby those associated with the person experiencing mental illness are themselves stigmatised (Corrigan & Watson, 2020). Home-based caregivers are often gossiped about, avoided in public spaces, excluded from religious activities, or subtly blamed during family gatherings. The symbolic logic here rests on associative contamination, where the presence of mental illness marks the entire family as socially deviant or spiritually polluted.

The cultural logic of blame is frequently gendered. In many African societies, home-based caregiving is a feminised role, and so too is the blame for failures in healing or protection. Women, particularly mothers and grandmothers, are expected to manage not only domestic labour but also the moral and spiritual well-being of the household. When a family member develops a mental illness, the assumption is often that the mother failed in her religious duties, parenting, or protection rituals (Munyaka & Letseka, 2020).

This form of stigma is compounded by spiritual narratives, such as amafufunyana (spirit possession) or ukuthwasa (calling to become a traditional healer), which frame mental illness in spiritual or mystical terms. While these explanations offer meaning, they can also intensify feelings of guilt and isolation when caregivers are accused of having failed to detect or prevent supernatural causes (Nguse & Wassenaar, 2021).

This dynamic is not confined to South Africa. In rural India, home-based caregivers of persons diagnosed with schizophrenia report being excluded from religious ceremonies and weddings due to beliefs that they carry spiritual contamination or bad karma (Das & Rao, 2021). In Brazil's favelas, where poverty is racialised and moralised, home-based caregivers are often seen as

irresponsible, having failed to raise a disciplined child or maintain household control, narratives that reinforce class-based and racial stigma (de Oliveira et al., 2022).

Similarly, in Uganda, home-based caregivers describe being called “bewitched” or accused of hiding family secrets, which allegedly caused the mental disorder (Whyte, 2020). These cases illustrate that home-based caregiver stigma is not only culturally embedded but also structurally reproduced, reinforcing existing hierarchies of class, gender, and moral worth.

The effects of such stigma are profound. Home-based caregivers in Clermont report experiencing anxiety, depression, social withdrawal, and family alienation. Some abandon religious or community groups that once served as sources of support, citing judgmental attitudes. Others internalise the blame, leading to self-doubt and a sense of failure. This aligns with Corrigan and Rao’s (2020) work on courtesy stigma, where individuals internalise negative stereotypes associated with their proximity to a stigmatised person. Moreover, extended family members may withdraw, either due to shame or fear of association, exacerbating economic strain and emotional isolation. For example, home-based caregivers often report having to quit work or reduce their hours, but receive little financial support from relatives, further compounding their burden (Molotsi & Mothiba, 2020).

From a feminist and intersectional perspective, stigma against home-based caregivers is experienced through multiple, overlapping forms of marginalisation. A Black woman home-based caregiver in Clermont may be dealing with:

- Racialised poverty
- Gendered caregiving expectations
- Stigmatised cultural interpretations of mental illness

- Lack of access to psychoeducation or supportive services

These intersecting identities place her at the connection of what Crenshaw (1989) terms structural vulnerability, where systemic oppression meets cultural exclusion. This illustrates that caregiver stigma is relational, gendered, and structurally embedded, calling for policy and service responses that address caregiver wellbeing as a critical public health priority.

Medical anthropology underscores the need to understand how stigma is socially constructed, culturally transmitted, and emotionally experienced. Policies must move beyond anti-stigma campaigns that focus solely on the ill individual and instead:

- Recognise the stigma experienced by home-based caregivers
- Create community-based psychoeducation programmes that include cultural leaders
- Engage faith institutions in dialogues around inclusive theology and non-punitive interpretations of mental illness
- Encourage community healing circles or home-based caregiver support groups rooted in local practices and language

While culture can provide valuable frameworks for understanding and managing mental illness, it can also serve as a vehicle for exclusion and blame. Caregiving responsibilities within families are frequently gendered, with women disproportionately assuming the emotional, physical and social burden of long-term mental health care in both Global South and Global North contexts (Choudhry et al., 2023; Akintola, 2020). Recognising and addressing these forms of secondary and cultural stigma is essential in building more empathetic, inclusive, and culturally competent mental health systems.

2.2.4 Cultural Silence and Internalised Shame

An often-overlooked dimension of socio-cultural marginalisation in the experience of mental illness, home-based caregiving is the enforced silence surrounding the condition. In many township settings like Clermont, KwaZulu-Natal, home-based caregivers are not only burdened with the practical and emotional demands of care but also pressured to remain silent about their struggles. This silence is culturally enforced and often spiritualised, operating through family norms, religious doctrines, and social expectations that discourage open discussion of mental illness.

Economy of silence is a socially imposed rule that relegates mental illness to the realm of taboo. According to Link and Phelan (2021), silence is a key mechanism of stigma, operating not only to marginalise the individual with the condition but also to erase public dialogue around the issue. In medical anthropology, silence is seen as both a cultural code and a structural effect, a mechanism that serves to maintain social harmony while suppressing dissenting or uncomfortable realities (Das, 2020).

Mental illness continues to be strongly stigmatised in many low-income and culturally diverse settings, where social exclusion, fear and misconceptions shape both help-seeking behaviour and caregiving experiences (Semrau et al., 2021; Campbell & Burgess, 2022). Within churches, prayer groups, or even traditional healing circles, home-based caregivers are often encouraged to rely solely on faith-based responses without naming or discussing the mental health condition. This silencing is sometimes framed as a test of faith, with home-based caregivers being told to “speak life” rather than “confess negativity.”

As a result, home-based caregivers internalise a logic where voicing distress is equated with spiritual weakness or defiance. Over time, this fosters what Bhugra

et al. (2021) refer to as internalised stigma, where the home-based caregiver comes to believe the negative messages imposed by their community and begins to self-silence, even in the presence of supportive resources. This internalisation is psychologically corrosive. Research by Gonzales et al. (2023) found that home-based caregivers who report higher levels of internalised shame are significantly more likely to experience depressive symptoms, emotional exhaustion, and social withdrawal. The effects are particularly acute among women, who are often positioned as both moral guardians and emotional home-based caregivers within patriarchal family structures (Munyaka & Letseka, 2020).

Cultural silence is not gender-neutral. In many township and rural communities, women are socialised into relational silence, taught that speaking about private matters, especially those involving family failure or mental disturbance, brings shame. This pressure is often intensified by religious teachings that position women as peacekeepers and spiritual intercessors, further discouraging them from openly expressing grief, anger, or fatigue (Monnapula-Mazabane & Petersen, 2023).

This silencing leads to what Foucault (1978) called the internalisation of surveillance, where individuals begin to regulate their own speech and emotions to conform to dominant norms, even in private. In such contexts, emotional suppression becomes a survival strategy, albeit one with long-term mental health costs.

Silence is not merely a cultural preference; it is often structurally enforced. South Africa's mental healthcare system remains largely biomedical and under-resourced, with few services offering culturally responsive psychoeducation or home-based caregiver counselling (Nguse & Wassenaar, 2021). Without access to mental health literacy or safe spaces for dialogue, home-based caregivers are left to interpret their experiences through spiritual or moralistic frameworks, often

blaming themselves or perceiving their suffering as divine punishment. This is compounded by a lack of public narratives that model open, non-judgmental discussions about mental illness and home-based caregiving. In contrast to the visibility given to other health conditions (e.g., HIV or diabetes), mental illness remains largely invisible in township community media, churches, and local governance discussions.

Cultural silence around mental illness is not unique to South Africa. In rural India, women home-based caregivers report being discouraged from speaking about mental illness in village councils or during festivals, fearing that disclosure will harm their family's marriage prospects or spiritual reputation (Das & Rao, 2021). In Japan, a culture that values social conformity, home-based caregivers of mentally ill family members are often silenced through implicit expectations of shame and familial discretion (Yamaguchi et al., 2021). Even in Western contexts, home-based caregivers often feel silenced by clinical professionals who focus exclusively on the patient, ignoring the home-based caregiver's emotional toll. This illustrates that silence, while culturally mediated, is also a structural function of many health systems, which neglect relational suffering in favour of individualised treatment.

Medical anthropologists argue for what Kleinman (2020 [reissue]) terms narrative justice, the recognition that stories of illness and care must be heard, validated, and included in the design of health systems. Breaking the silence involves not just encouraging speech, but creating culturally safe spaces where home-based caregivers can speak without fear of moral judgment, spiritual invalidation, or institutional neglect.

Effective interventions might include:

- Faith-based psychoeducation programmes that integrate spiritual and clinical understandings

- Peer-led home-based caregiver support circles in local languages
- Public storytelling platforms (radio, theatre, local clinics) that normalise discussion of mental illness and care
- Training for pastors, traditional leaders, and nurses to recognise and support home-based caregiver distress

Cultural silence and internalised shame form a hidden yet powerful centre line of home-based caregiver suffering in mental illness contexts. In Clermont and similar communities, home-based caregivers, particularly women, are encouraged to suffer in silence, suppress their emotions, and endure judgment with resilience. This silencing contributes to a cycle of psychological isolation, internalised stigma, and barriers to seeking help. From a medical anthropology perspective, addressing cultural silence is not simply a matter of promoting awareness; it requires a reimagining of communal, religious, and healthcare spaces as sites of emotional recognition, narrative inclusion, and relational healing.

2.2.5 Symbolic and Spiritual Meaning as a Coping Tool

Home-based caregiving for persons diagnosed with mental illness in structurally constrained settings has been widely documented in global mental health scholarship as a profoundly complex social practice characterised by emotional strain, moral responsibility, and culturally embedded meaning-making processes (Kirmayer & Pedersen, 2021; Lund et al., 2022). In many low-resource environments, caregiving is not only experienced as a practical obligation but also as a deeply symbolic and existential engagement through which caregivers interpret suffering, negotiate identity, and sustain hope amidst institutional neglect. Medical anthropological research emphasises that symbolic and spiritual

explanatory frameworks often emerge where biomedical systems are fragmented or culturally incongruent, enabling caregivers to reinterpret distress within locally coherent moral worlds (Bhugra et al., 2021; Kleinman, 2020). Within township contexts such as Clermont, these interpretive strategies frequently draw upon ancestral cosmologies, Christian theology, and communal ethical systems such as Ubuntu, thereby transforming caregiving from a purely burdensome activity into a morally meaningful social role. Such culturally grounded meaning-making has been shown to function as a psychosocial coping resource that enhances resilience, emotional endurance, and relational identity reconstruction among family caregivers (Monnapula-Mazabane & Petersen, 2023; Silaule et al., 2024).

Medical anthropology recognises that symbolic systems, rituals, spiritual beliefs, and cosmologies can be as important to healing as pharmacological interventions. Kirmayer and Pedersen (2021) argue that symbolic practices provide culturally coherent models for understanding distress, managing uncertainty, and restoring balance. These practices do not simply aim to “cure” an illness but work to reorder the social and spiritual worlds of those affected. In the context of mental illness, symbolic rituals such as *ukuhlambulula* (cleansing ceremonies), *ukuphahla* (ancestral invocation), and church-based deliverance sessions act as therapeutic interventions not in a biomedical sense, but in terms of emotional regulation, moral alignment, and community reintegration (Monnapula-Mazabane & Petersen, 2023).

Home-based caregivers often report that these practices offer a sense of structure, rhythm, and collective meaning, which is notably absent in the often-technical and isolating environment of psychiatric care. They facilitate an emotional transition from chaos to coherence, enabling home-based caregivers to “make sense” of their suffering.

Spiritual narratives also provide a platform for transformative identity work. By interpreting mental illness as a test from God, a spiritual calling, or even a sacred burden, home-based caregivers develop narratives of endurance and transcendence. These belief systems offer explanations that link suffering to moral growth, intergenerational healing, and divine purpose, often alleviating guilt and despair. This is particularly relevant in post-apartheid South Africa, where trauma, loss, and social rupture are part of many families' historical narratives. In this setting, symbolic meaning serves as a form of resistance and restoration, reconnecting individuals to ancestral knowledge systems that were marginalised under colonial and apartheid rule (Munyaka & Letseka, 2020). This framing transforms mental illness from a pathological disruption into a spiritual initiation, offering home-based caregivers both cultural legitimacy and existential purpose. Such interpretations echo what Viktor Frankl (2020 reprint) described as “meaning-making in suffering,” which has been shown to increase psychological resilience and post-traumatic growth.

These meaning-making strategies are not exclusive to African contexts. In Latin America, home-based caregivers of children with disabilities often draw on Catholic teachings to interpret home-based caregiving as a “gift of divine responsibility”, which helps reframe the experience from stigma to sacrifice (de Oliveira et al., 2022). In India, home-based caregivers rely on Hindu cosmology to understand mental illness as karma or as part of a spiritual cycle of rebirth and cleansing (Das & Rao, 2021). In rural Appalachia, home-based caregivers of persons with schizophrenia report relying on Biblical metaphors and communal prayer as ways to interpret and manage home-based caregiving stress, often in the absence of formal services (Gonzales et al., 2023). These global examples affirm that spiritual meaning-making is a transcultural phenomenon, deeply intertwined with local cosmologies, moral economies, and social structures.

The symbolic reframing of home-based caregiving not only aids individual resilience but also fosters community belonging. Participation in rituals such as healing ceremonies, church vigils, and family cleansing rites reinforces intergenerational ties, validates shared values, and situates home-based caregiving within a broader cosmological narrative. This aligns with the Ubuntu philosophy, a Southern African ethic of interconnectedness which emphasises that “a person is a person through others.” Home-based caregiving, when spiritually contextualised, becomes a collective moral project, supported by elders, ancestors, and divine forces. Such meaning-making fosters a sense of communal coherence, even in situations of extreme adversity (Munyaka & Letseka, 2020).

Despite the significance of symbolic practices, mental health systems in South Africa remain predominantly biomedical and often dismiss these traditions as unscientific. This neglects the therapeutic role of culture and alienates home-based caregivers who derive emotional sustenance from spiritual meaning.

Medical anthropologists advocate for inclusive care models that:

- Recognise the coping function of symbolic rituals
- Engage with faith-based organisations as allies in mental health
- Collaborate with traditional healers and spiritual leaders in culturally appropriate ways
- Provide training for psychiatric professionals in cultural humility and narrative competence

Such approaches would not only honour home-based caregivers’ meaning systems but also bridge the epistemological gap between Western psychiatry and indigenous knowledge.

For home-based caregivers in Clermont Township, symbolic and spiritual frameworks do more than explain mental illness; they offer tools for emotional survival, identity reconfiguration, and spiritual growth. In contexts where biomedical resources are limited and stigma is high, symbolic meaning-making becomes a form of cultural resistance and psychosocial resilience. Understanding and validating these narratives is not a matter of “cultural tolerance” but a moral imperative in building mental health systems that are inclusive, responsive, and just.

Mental illness, in the context of Clermont Township and many African communities, is not merely a biomedical diagnosis; it is a culturally mediated experience, interpreted through layers of spiritual belief, moral responsibility, social expectation, and historical consciousness. For home-based caregivers, particularly women, the act of home-based caregiving becomes embedded in a matrix of symbolic meaning, social pressure, and emotional labour that often extends beyond the visible clinical realm.

Throughout this section, we have seen that home-based caregivers draw upon pluralistic care systems that span traditional healing, Christian or ancestral spirituality, and psychiatric medicine. These approaches are not mutually exclusive but are often pursued simultaneously, reflecting localised logics of healing and care-seeking. Such pluralism is not indicative of confusion or rejection of science but rather a rational, adaptive response to a fragmented and often culturally incongruent formal health system (Monnapula-Mazabane & Petersen, 2023; Kirmayer & Pedersen, 2021).

At the same time, these systems are not without contradictions or consequences. Cultural framings of mental illness as witchcraft, ancestral calling, or divine punishment frequently produce secondary stigma, placing blame on home-based caregivers for failing to pray enough, follow ancestral instructions, or morally

guard their household. This can lead to gendered scapegoating, where mothers and female relatives become the symbolic bearers of failure, shame, or spiritual pollution (Link & Phelan, 2021; Munyaka & Letseka, 2020).

Furthermore, the dominant culture of silence discourages caregivers from seeking help, voicing frustration, or acknowledging their emotional distress. The expectation to endure quietly, reinforced by religious doctrines, community gossip, and internalised shame, creates a psychosocial double burden, where home-based caregivers not only manage the illness but also bear the emotional weight of concealment and self-blame (Nguse & Wassenaar, 2021; Gonzales et al., 2023).

Yet, in the midst of these challenges, home-based caregivers also cultivate resilience through symbolic meaning-making. By interpreting their journey as a test of faith, spiritual mission, or ancestral calling, many home-based caregivers transform suffering into sacred labour. Rituals like *ukuhlambulula* (cleansing) or church deliverance services provide not just spiritual reassurance but psychological scaffolding offering control, continuity, and belonging in an otherwise disempowering experience (Kleinman, 2020; Bhugra et al., 2021).

From a medical anthropology perspective, these home-based caregiving realities challenge narrow psychiatric models that focus exclusively on symptomatology, diagnosis, and medication adherence. Instead, they call for an approach that is culturally situated, morally attuned, and relationally grounded. As scholars like Kleinman (2020) and Kirmayer (2021) argue, the work of home-based caregiving is not simply technical; it is also deeply emotional, moral, and symbolic, shaped by sociocultural logics that must be engaged rather than dismissed. Understanding mental illness and home-based caregiving in settings like Clermont thus requires multilayered analysis: attention to culture, gender, spirituality, structural inequality, and community belief systems. Only then can

interventions be designed that are not only clinically effective but also culturally respectful and emotionally responsive.

In sum, home-based caregiving in resource-constrained, culturally complex environments is marked by a dual experience: one of marginalisation and meaning-making, stigma and spirituality, burden and resilience. Recognising this complexity is essential to creating mental health systems that support, rather than undermine, the emotional and symbolic labour of care.

2.3. The Feminisation of Care Work

Feminist theorists have long challenged the pervasive assumption that women are “naturally” predisposed to care, especially within domestic and familial contexts. This social construct, rooted in patriarchal ideologies, frames home-based caregiving as an extension of maternal instinct or feminine compassion rather than a form of skilled, emotionally intensive, and economically valuable labour (Tronto, 2021; hooks, 2020). In doing so, it obscures the structural inequities that assign home-based caregiving roles almost exclusively to women, often without adequate recognition, resources, or institutional support.

In township settings such as Clermont, KwaZulu-Natal, this dynamic is highly visible. Mental health home-based caregiving is overwhelmingly performed by women, mothers, aunts, daughters, and grandmothers who assume full responsibility for managing psychiatric symptoms, navigating clinic systems, providing emotional containment, and mediating between the ill person and the broader community. These home-based caregiving roles are rarely voluntary; instead, they are shaped by cultural expectations, kinship structures, and religious beliefs that view women as morally obligated to “hold the family together” (Mmereki & Molefi, 2025; Nguse & Wassenaar, 2021).

“My husband left when my son got diagnosed. Now I’m everything his mother, his nurse, his guard. I haven’t worked in five years.”

43-year-old caregiver, KwaZulu-Natal (Craig et al., 2023)

This poignant quote reflects the life-altering consequences of home-based caregiving for women. The feminisation of care leads to occupational withdrawal, financial insecurity, social isolation, and psychological exhaustion. Yet these effects are often rendered invisible under the guise of duty, love, or familial loyalty.

From a medical anthropological perspective, care extends far beyond routine physical assistance. It is deeply symbolic and moral labour, especially in African communities where mental illness is often framed through spiritual or cosmological interpretations. Home-based caregivers in these contexts become mediators between biomedical systems, spiritual healers, ancestral expectations, and societal judgment (Monnapula-Mazabane & Petersen, 2023; Bhugra et al., 2021). Their home-based caregiving tasks may include not only managing medications but also performing cleansing rituals (*ukuhlambulula*), engaging in protective prayer, or consulting spiritual leaders often without guidance or integration into formal healthcare structures.

This layered home-based caregiving practice is intellectually and emotionally taxing. It requires cultural fluency, spiritual discernment, and emotional labour, none of which are acknowledged by the mental health system. Feminist theorists like Hochschild (revisited by Gonzales et al., 2023) describe this as “emotional labour,” where women are expected to absorb and contain distress without displaying signs of burnout, anger, or fatigue. Home-based caregiving in this context is not merely gendered; it is part of what scholars term a gendered moral economy. Women are often blamed if care outcomes are unfavourable or if the ill relative exhibits violent or socially disruptive behaviour. This moral burden is

further compounded by the lack of state recognition and the social costs of visible failure, especially in patriarchal societies where women's worth is linked to family well-being (Raphal, 2023).

International studies reinforce these patterns. In rural India, for instance, Das and Rao (2021) describe how female home-based caregivers are blamed for the spiritual contamination of their households when mental illness occurs. In Brazil, mothers of mentally ill children face blame for their children's breakdowns, seen as a result of poor mothering or lack of religious commitment (de Oliveira et al., 2022). In all these settings, women's home-based caregiving is constructed not only as a labour of love but as a spiritual and moral test, in which failure invites condemnation, not support.

The feminisation of care must also be understood as a form of structural violence where the absence of institutional support, healthcare integration, economic protection, or psychosocial services systematically harms women while disguising this harm as cultural or familial duty (Farmer, 2020; Tronto, 2021). In Clermont, home-based caregivers report sacrificing not only time and income but also their sense of self. Such experiences underscore the erosion of identity that comes with intensive, unsupported home-based caregiving. Feminist thinkers argue for reframing care not just as a "women's issue" but as a social justice issue, calling for recognition, compensation, and shared responsibility (hooks, 2020; Raphal, 2023).

Despite South Africa's progressive stance on gender and health, mental health caregiving remains glaringly absent from national policy. The Mental Health Care Act and the National Mental Health Policy Framework (2023–2030) emphasise community-based care but fail to address the realities of home-based caregiving, especially the gendered burden it entails. There is no provision for:

- Home-based caregiver stipends

- Respite care
- Mental health counselling for home-based caregivers
- Legal protections for unpaid carers

This policy vacuum further entrenches the idea that home-based caregiving is “women’s work” done quietly, at home, and without complaint (Ndlovu, 2022).

The feminisation of care work is not confined to South Africa. In high-income countries like the UK, US, and Canada, women still provide over 70% of unpaid care for relatives with mental illness, despite having formal employment (Gonzales et al., 2023). In East Asia, daughters-in-law are often burdened with eldercare duties based on patriarchal traditions of filial piety (Kim & Lee, 2021). These global parallels reveal that while the specific cultural logics may differ, the gendered dynamics of home-based caregiving remain persistent and under-addressed.

The feminisation of mental health home-based caregiving in Clermont Township reflects a broader global pattern of assigning emotional, spiritual, and physical home-based caregiving labour to women without institutional or economic support. Framed as a moral duty, home-based caregiving becomes a site of exploitation, invisibility, and structural neglect, where women shoulder disproportionate burdens under the guise of love and family responsibility.

To shift this paradigm, feminist scholars and mental health advocates argue for:

- Formal recognition of home-based caregiving as labour
- Inclusion of home-based caregiver support in mental health policy
- Gender-sensitive mental health training
- Economic and emotional relief mechanisms

- Public awareness campaigns to challenge stigma and redistribute care responsibilities

Ultimately, understanding home-based caregiving through both a feminist and medical anthropology lens allows for a more delicate and justice-oriented approach, one that values the complex work women perform and demands systemic transformation.

While the feminisation of mental health home-based caregiving is clearly visible in South African townships like Clermont, it reflects a broader global pattern of structurally gendered care work. Across diverse economic, geographic, and cultural contexts, women overwhelmingly bear the burden of caring for individuals diagnosed with mental illness. This pattern persists regardless of whether countries are low-income with minimal healthcare infrastructure or high-income with robust mental health systems, suggesting that the gendered division of home-based caregiving labour is a transnational and systemic phenomenon (Spencer & Gill, 2023; Garcia & Reyes, 2021).

In Brazil's urban favelas, de Oliveira et al. (2022) documented how home-based caregiving for persons with mental illness is predominantly carried out by women, especially single mothers and elderly grandmothers. These women are not only expected to provide physical and emotional care, but also to absorb the consequences of poverty, public neglect, and stigma. Many home-based caregivers report abandoning formal employment to stay home, while receiving little to no support from the state or extended family.

“I haven’t worked in years because he needs me. The government says go to the clinic, but who stays with him while I go?”

— Caregiver, Rio de Janeiro (de Oliveira et al., 2022)

This quote echoes experiences in Clermont, revealing how state health directives often fail to accommodate the real-life conditions of female caregivers. Mental health interventions rarely include provisions for childcare, transport, or caregiver support—thereby making healthcare access structurally exclusive.

In the rural Philippines, Garcia and Reyes (2021) reported that mothers of children diagnosed with psychiatric disorders frequently face intense social blame and ostracism. Mental illness is often interpreted through moral or behavioural frameworks, where the mother is seen as having “failed” in her parenting duties. Women are excluded from religious and social gatherings and may even be advised to isolate their children to avoid community shame.

“They said I raised my child wrong. No one invites us anymore.”

—Mother, Luzon (Garcia & Reyes, 2021)

This moral blaming aligns with South African cultural logics that tie maternal care to spiritual or ancestral responsibility. As such, home-based caregiving is not just labour; it becomes a test of womanhood, morality, and social respectability, which can lead to internalised guilt and emotional distress (Nguse & Wassenaar, 2021).

In Kenya, Okello et al. (2024) describe the home-based caregiving experience as a form of spiritual and social confinement. Female home-based caregivers, particularly in rural and semi-urban areas, report that their roles have effectively removed them from society. Religious leaders may frame the mental illness as a spiritual curse, requiring the caregiver to perform continuous rituals and limit their social interactions. These women describe home-based caregiving as not only exhausting but also imprisoning.

“I’m not just a home-based caregiver. I’m a prisoner of this role.”

— Female caregiver, Kisumu County (Okello et al., 2024)

This resonates strongly with findings in Clermont, where caregivers report loss of identity and personal agency (Craig et al., 2023). Whether through cultural expectation or spiritual obligation, home-based caregiving becomes a totalising identity, one that subsumes all other life roles.

Even in contexts with advanced healthcare systems, gendered inequalities in home-based caregiving persist. In Canada, Spencer and Gill (2023) found that women are significantly more likely than men to reduce their work hours, forgo promotions, or exit the workforce entirely to care for mentally ill family members. Despite legal protections for unpaid home-based caregivers and social welfare schemes, institutional sexism and gendered expectations remain entrenched. Statistical data revealed that over 72% of unpaid home-based caregivers for individuals with psychiatric disorders were women. Many of them experienced workplace discrimination, mental health decline, and financial strain.

“They said I could take time off for caregiving, but I was passed over for the promotion. I feel punished for being there for my sister.”

— Professional woman, Ontario (Spencer & Gill, 2023)

This reveals a common thread: even in progressive policy environments, home-based caregiving is still viewed as a woman’s private responsibility rather than a shared societal obligation. The labour of care is undervalued and invisible, even when performed within formal structures.

These examples from Brazil, the Philippines, Kenya, and Canada demonstrate the global pervasiveness of gendered home-based caregiving burdens. What varies are the cultural scripts, religious in East Africa, maternal in Southeast Asia,

structural in Latin America, and economic in North America, but the core gendered logic remains intact. Women are consistently expected to:

- Sacrifice personal ambitions
- Absorb institutional failures
- Manage the emotional, spiritual, and physical needs of others
- Endure without complaint

From a feminist perspective, this reflects a global moral economy where women's home-based caregiving is morally expected but materially unsupported (Tronto, 2021; hooks, 2020). These burdens are compounded by stigma, economic precarity, and a lack of policy protection.

Medical anthropologists highlight that the gendered expectations of home-based caregiving are not natural but constructed and maintained by social, cultural, religious, and state mechanisms that relegate care to the private sphere, often to the detriment of women's health and autonomy (Kirmayer & Pedersen, 2021; Farmer, 2020).

The feminisation of home-based caregiving for people with mental illness is not limited to South Africa; it is a global, systemic phenomenon. Across both the Global North and South, women disproportionately shoulder the responsibilities of home-based mental health care. Whether bound by cultural beliefs, economic constraints, or state neglect, caregiving becomes a site of gendered sacrifice, social exclusion, and emotional burden.

To challenge this norm, feminist and medical anthropology scholars call for:

- Global home-based caregiver support systems embedded in mental health policy

- Economic compensation for unpaid care
- Community-based mental health education to reduce stigma
- Public campaigns to redistribute home-based caregiving responsibilities
- Structural interventions to centre gender equity in healthcare

Only by recognising home-based caregiving as both a labour and social justice issue can we begin to transform these persistent global inequalities.

2.4 Coping Mechanisms Among Home-Based Caregivers

This section explores the diverse ways in which home-based caregivers of persons with mental illness manage the emotional, physical, social, and spiritual burdens of home-based caregiving in under-resourced contexts such as Clermont Township, KwaZulu-Natal. It critically examines both constructive and harmful coping strategies, guided by a medical anthropology perspective which understands coping not just as a psychological process but as a culturally and structurally situated response to sustained stress, social marginalisation, and spiritual meaning-making (Kirmayer & Pedersen, 2021).

Home-based caregiving in low-resource settings is often chronic, unrelenting, and unsupported by formal institutions. As a result, coping mechanisms are shaped by necessity, creativity, and the symbolic frameworks available to caregivers. These mechanisms range from spiritual rituals and peer support networks to emotional suppression, avoidance, and resignation.

2.4.1. Spiritual and Religious Coping

In African contexts, spirituality is not merely a form of belief but a social practice and coping resource that informs how individuals interpret illness, suffering, and

home-based caregiving. For many home-based caregivers in under-resourced settings, spirituality functions as a moral anchor, emotional refuge, and source of cultural coherence in the context of chronic mental illness caregiving.

Home-based Caregivers frequently turn to Christianity, indigenous belief systems, Zionist traditions, and ancestral cosmologies to locate meaning in their home-based caregiving experiences.

Such expressions are not uncommon and reflect what Monnapula-Mazabane and Petersen (2023) describe as spiritually embedded resilience, the capacity to endure suffering by framing it within religious or ancestral cosmologies. Illness is interpreted not only as a biomedical event, but as a spiritually significant occurrence: a test of faith, ancestral displeasure, or a manifestation of moral imbalance within the family or community.

Religious participation is not only about private belief. It also offers:

- Emotional validation through prayer and fellowship
- Ritual support, including laying on of hands, anointing, fasting, or cleansing
- Community containment, as churches often serve as informal support networks

Zionist and Pentecostal churches in townships frequently provide home-based caregivers with ritualised forms of hope, transforming home-based caregiving from a burden into a redemptive or spiritual calling. Religious idioms such as “carrying the cross,” “God’s plan,” or “a test of faith” are commonly invoked, not as denial but as a meaning-making device that sustains caregivers amid uncertainty (Kirmayer & Pedersen, 2021).

In many African communities, traditional healing practices are often used alongside biomedical care as part of pluralistic health-seeking strategies rather than as simple alternatives to formal treatment. When mental illness is interpreted as bewitchment, ancestral calling, or spiritual pollution, home-based caregivers seek assistance from inyangas or sangomas to protect both the patient and themselves. These interventions may involve:

- Cleansing rituals (ukuhlambulula)
- Animal sacrifice (ukubuyisa or ukuhlatswa)
- Herbal medicines (muthi)
- Ancestral consultations (kubhula)

These practices reflect pluralistic health-seeking behaviour rooted in cultural logics. Rather than being considered superstitious or irrational, they serve as symbolic strategies for reclaiming agency, managing uncertainty, and restoring cosmic balance (Bhugra et al., 2021).

Such practices are not unique to South Africa. In Uganda, Kaggwa et al. (2022) found that home-based caregivers interpreted their role as divinely appointed, using prayer and ritual as psychological tools for endurance and spiritual alignment. Similarly, in Ghana, home-based caregivers frequently alternate between psychiatric clinics and shrine visits, citing the need to address both physical and metaphysical causes of illness (Asare & Danquah, 2020).

From a medical anthropological perspective, spiritual and religious coping mechanisms are culturally coherent responses to suffering. They allow home-based caregivers to:

- Construct personal meaning in situations of helplessness

- Affirm moral worth despite social judgment
- Transform home-based caregiving into a spiritually valuable task

These practices offer symbolic efficacy, a sense that the home-based caregiver is doing something, protecting the home, and fulfilling their moral obligations. As Kirmayer et al. (2021) argue, symbolic actions like prayer and ritual should not be dismissed as escapism but appreciated for their emotional, cognitive, and existential value.

Despite their benefits, spiritual and religious coping strategies are not without tension. Some home-based caregivers may feel guilt when healing does not occur, questioning their own faith or ancestral piety. Others face moral conflict between psychiatric advice and spiritual interpretation, leading to delayed treatment or treatment discontinuation. Furthermore, some churches discourage open discussion of mental illness, advising only prayer and ignoring the need for psychiatric intervention (Gonzales et al., 2023).

Nonetheless, even in such cases, the spiritual idiom allows home-based caregivers to survive emotionally in the absence of state-supported psychological services. Spiritual and religious coping represents a vital and culturally grounded resource for home-based caregivers in many low-resource and pluralistic care settings. Whether through Christian prayer, Zionist ritual, or ancestral cleansing, these practices allow caregivers to reframe suffering as spiritually purposeful, thus enabling endurance in otherwise unbearable conditions. When understood through a medical anthropology lens, these strategies are not only adaptive but essential, especially in settings where biomedical systems offer little emotional, existential, or social support.

2.4.2 Social Support and Kinship-Based Strategies

In the absence of adequate formal institutional support, home-based caregivers of persons with mental illness often rely heavily on informal social and kinship-based networks for both emotional support and practical assistance. In collectivist African societies, home-based caregiving is embedded within a broader web of reciprocal relationships, where neighbours, extended family, friends, and church members constitute essential safety nets (Van der Geest & Whyte, 2020; Nguse & Wassenaar, 2021).

Such acts of everyday solidarity reflect what anthropologists Stack and Burton (1993) describe as “kin work”, the unpaid, socially embedded labour of care exchanged among kin and community members, often outside the structures of the formal economy. Kin work is especially critical in township settings where material deprivation, spatial precarity, and unemployment severely constrain access to paid services and state support.

The literature indicates that home-based caregivers frequently rely on:

- Rotational support from family members for meal preparation or errands
- Neighbours offering intermittent assistance, such as childcare or accompaniment to clinics
- Church groups offering prayer, companionship, and occasional material donations

These forms of home-based care extend beyond practical help; they serve as social affirmations of the caregiver’s humanity and worth in a context where mental illness is often stigmatised and silenced (Monnapula-Mazabane & Petersen, 2023). Kin-based support becomes not only a buffer against burnout but also a form of social and cultural recognition.

Despite their importance, these support systems are often fragile and contingent, especially where stigma prevails. When mental illness is perceived as a threat to moral or spiritual order, families and communities may distance themselves from both the patient and the caregiver. This breakdown is frequently triggered by:

- Fear of violent outbursts
- Beliefs about ancestral punishment or witchcraft
- Concerns about spiritual pollution or bad luck

Such experiences exemplify secondary stigma, where the home-based caregiver becomes socially marked by association with the ill person (Link & Phelan, 2021). The emotional toll of this rejection is immense, often resulting in depression, social withdrawal, and identity erosion (Craig et al., 2023).

To reduce isolation and stigma, home-based caregivers in various settings have formed informal support groups, often organised through churches, clinics, or community-based organisations. These groups offer:

- Shared knowledge of how to handle psychiatric symptoms
- A safe space for venting frustrations
- Spiritual encouragement and collective prayer
- Solidarity in confronting exclusion and social judgment

Although these groups are rarely funded or formally recognised, they represent an important mode of peer-based resilience. According to Gonzales et al. (2023), such informal structures serve as “microsystems of care”, providing emotional scaffolding in the absence of systemic support.

In Zimbabwe, for example, Munodawafa et al. (2021) documented community-initiated support circles where grandmothers caring for mentally ill grandchildren met weekly to discuss challenges, share traditional remedies, and pray together. These groups had therapeutic effects, reducing feelings of loneliness and enhancing caregivers' sense of purpose and solidarity.

From a medical anthropology perspective, social support is not simply a psychological buffer but a form of embedded, relational coping shaped by culture, gender, and history (Kirmayer & Pedersen, 2021). In African settings, home-based caregiving is conceptualised not as an individual task, but as a relational obligation, one that implicates the entire household and often, the wider community. However, when stigma disrupts these relational networks, caregivers are left not only to manage the illness but also to absorb the full social and emotional cost of failed kinship support.

Moreover, care in such contexts is not transactional but reciprocal, where today's helper may be tomorrow's patient. This circularity underscores the cultural logic of ubuntu, the African philosophy of mutual care and shared humanity. Yet, as noted by Ndlovu (2022), the erosion of communal values under economic strain and social fragmentation has rendered many home-based caregivers increasingly alone, undermining the traditional protective function of extended kin networks.

Social support and kinship-based strategies remain among the most vital and culturally grounded coping mechanisms for home-based caregivers in township and other under-resourced community settings. While these systems provide emotional relief, practical assistance, and symbolic affirmation, they are also fragile and easily disrupted by stigma, fear, and economic stress.

In the absence of a formal care infrastructure, these informal networks do the work of the state, sustaining life and sanity under impossible conditions.

Recognising, resourcing, and reinforcing these social fabrics must therefore be a priority in mental health interventions, particularly in low-resource settings.

2.4.3 Harmful Coping: Avoidance and Emotional Suppression

While many home-based caregivers adopt creative and resilient coping mechanisms, others, especially those operating in contexts of chronic stress, social stigma, and institutional neglect, resort to maladaptive or harmful coping behaviours. These behaviours, such as emotional suppression, avoidance, denial, and psychological detachment, often arise not from choice but from exhaustion and the lack of alternative, supportive outlets (Kirmayer & Pedersen, 2021).

A caregiver in Durban reflected on this internal struggle:

“I try not to think too much. If I feel everything, I’ll collapse. So I just keep busy with chores. Emotions can wait.”

— (Montgomery et al., 2024)

This quote illustrates a deeply human response to chronic emotional labour, a strategy of psychological compartmentalisation used to remain functional in the face of overwhelming emotional strain.

In many African contexts, particularly among older generations, expressing vulnerability, especially for women, is discouraged. Cultural expectations around strength, sacrifice, and maternal duty often silence home-based caregivers’ emotional pain (Nguse & Wassenaar, 2021). This creates a culture of stoicism, where suffering is internalised, and home-based caregiving is framed as a duty to be endured rather than a shared social responsibility.

Medical anthropologists argue that emotional suppression is not merely personal, but socially and structurally conditioned. Home-based caregivers are often unacknowledged in policy, unsupported by healthcare institutions, and silenced within their families or communities due to the stigma surrounding mental illness (Bhugra et al., 2021). As a result, avoidance becomes a psychological and social defence mechanism, used to maintain control and stability in an uncontrollable situation.

In rural Uganda, Kaggwa et al. (2022) found that home-based caregivers routinely avoided discussing their emotions or the illness for fear of judgment or spiritual retribution. One mother said:

“Speaking about it brings shame. I’d rather pray and be quiet than have people pity me.”

While avoidance may allow home-based caregivers to function in the short term, it often leads to emotional disengagement, a condition commonly referred to as compassion fatigue. In this state, the caregiver continues to provide physical care but becomes emotionally detached, performing home-based caregiving tasks robotically, without empathy or emotional presence (Gonzales et al., 2023).

Over time, compassion fatigue can escalate into burnout, characterised by:

- Chronic fatigue
- Irritability or resentment towards the care recipient
- Feelings of helplessness and hopelessness
- Withdrawal from social and familial relationships
- In extreme cases, neglect or unintentional harm

These outcomes are often misread as home-based caregiver failure or incompetence. However, feminist and medical anthropology scholars emphasise that they are more accurately understood as symptoms of structural violence where the home-based caregiver's emotional collapse is a rational response to prolonged invisibility, overwork, and isolation (Farmer, 2020; Tronto, 2021).

The burden of emotional suppression is heavily gendered. Women, who constitute the majority of home-based caregivers in many low-resource contexts, are often socially expected to display resilience, faith, and selflessness, even at considerable personal cost. Expressions of fatigue, sadness, or frustration may be judged as signs of weakness or spiritual failing (hooks, 2020).

International studies confirm that harmful coping mechanisms are prevalent among home-based caregivers across diverse socio-economic and cultural settings. In South Korea, Lee et al. (2022) found that female home-based caregivers of mentally ill family members frequently suppressed emotion due to cultural norms of shame and family honour, which often resulted in anxiety and depression. Similarly, in Brazil, de Oliveira et al. (2022) documented high levels of burnout and substance use among mothers of schizophrenic sons, who lacked social support and feared public stigma.

These parallels indicate that harmful coping mechanisms are global in nature, though shaped by local cultural logics and gender norms. Avoidance, emotional numbing, and silence must therefore be understood not as pathology, but as contextually shaped responses to overwhelming caregiving demands and structural abandonment.

Rather than pathologising avoidance, scholars such as Kirmayer et al. (2021) argue that such behaviours should be reframed as survival strategies in contexts of chronic distress. Emotional numbing allows home-based caregivers to

continue functioning when their emotional capacities are exhausted. In this sense, even harmful coping is a form of resilience, albeit one with long-term costs.

This interpretation aligns with Farmer's (2020) concept of structural violence, where home-based caregivers' suffering is not caused by personal failure, but by policy neglect, economic marginalisation, and the gendered devaluation of care. Any intervention aimed at home-based caregiver wellbeing must therefore move beyond individual therapy to include systemic change, including respite services, financial support, peer counselling, and public recognition of caregivers' needs.

Avoidance and emotional suppression are commonly described among home-based caregivers in under-resourced settings, not because caregivers are emotionally deficient, but because they are responding to sustained emotional overload and limited support. These coping strategies emerge in response to stigma, isolation, chronic stress, and lack of institutional support. While they may enable short-term survival, they often contribute to long-term burnout and compassion fatigue. Understanding these behaviours through a medical anthropology and feminist lens shifts the focus from blaming caregivers to interrogating the structural conditions that produce harmful coping. Only by recognising these dynamics can health systems and policymakers develop culturally sensitive, gender-aware interventions that provide genuine relief to overburdened caregivers.

2.5. Global and Community-Based Caregiving Models

This section explores global innovations and community-based approaches to home-based caregiving for persons diagnosed with mental illness, particularly as they relate to home-based caregivers in under-resourced contexts like Clermont Township, KwaZulu-Natal. While mental illness is often framed in clinical terms, home-based caregiving, especially within families, is a social practice shaped by cultural ethics, local networks, and community responses. Drawing from a medical anthropology lens, this section highlights how different

societies, both in the Global South and North, develop collective, locally adapted home-based caregiving models, and what lessons they offer for township-based caregiving systems in South Africa.

2.5.1 Ubuntu and the Ethics of Relational Care

The African philosophy of Ubuntu, often expressed through the isiZulu maxim “*Umuntu ngumuntu ngabantu*”, meaning “a person is a person through other people”, provides a profound ethical framework for understanding home-based caregiving in South African communities. Ubuntu centres on relational interdependence, collective solidarity, empathy, and shared responsibility, making it highly relevant for contexts where home-based caregiving for persons with mental illness is carried out informally within the home and community (Munyaka & Letseka, 2020; Louw, 2022).

In township and other under-resourced settings where mental health infrastructure is weak, Ubuntu functions not only as a moral ideal but also as a practical ethic of survival and mutual care. It creates a moral economy of care, where neighbours, extended family members, and faith-based networks offer emotional and material support. This is the enduring essence of Ubuntu in contexts marked by structural vulnerability. Despite chronic poverty, unemployment, and inadequate state services, home-based caregivers often draw strength from informal reciprocal ties. These ties reflect what anthropologists describe as “relational autonomy”, where individuals maintain agency through interdependence, rather than isolation (Kirmayer & Pedersen, 2021).

However, the practical expression of Ubuntu has been eroded by neoliberal pressures and urbanisation. As South Africa’s economic landscape becomes increasingly individualised and fragmented, the communal safety nets that traditionally sustained home-based caregiving roles are being weakened. Women, who disproportionately shoulder home-based caregiving duties, are often left with a contradictory burden: expected to care as “good community members,” yet without the material resources or institutional support needed to do so (Nguse & Wassenaar, 2021; Mmereki & Molefi, 2025).

Medical anthropologists have highlighted the importance of reinvigorating indigenous ethics like Ubuntu in public health frameworks, not as romanticised cultural ideals, but as pragmatic, culturally coherent logics that inform how communities already manage illness and caregiving (Monnapula-Mazabane & Petersen, 2023). Ubuntu, when supported by policy, could serve as

the basis for designing community-led mental health programmes that respect relational identities and shared caregiving responsibilities.

For example, local initiatives such as church-based caregiver support groups, community health forums, and izimbizo (community dialogues) can serve as platforms to operationalise Ubuntu in mental health care delivery. These spaces allow for peer exchange, cultural validation, and collaborative problem-solving, fostering both psychological resilience and social cohesion (Ndlovu, 2022).

Moreover, feminist theorists argue that Ubuntu can challenge the invisible gendering of home-based care by reframing it as a communal ethic rather than a woman's moral duty. If home-based caregiving is seen as a collective responsibility, not just a feminine role, then the burden may be more equitably distributed and more likely to attract policy attention and social support (Tronto, 2021; hooks, 2020).

Ubuntu offers a culturally resonant, ethically rich framework through which to reimagine home-based caregiving in township contexts. It challenges Western notions of individualism by foregrounding the social embeddedness of care. In contexts where home-based caregiving occurs under conditions of economic precarity and institutional neglect, Ubuntu may provide both a moral framework for care and a basis for community mobilisation, resilience-building, and advocacy.

Future mental health policies should actively engage with Ubuntu as a foundational principle, integrating it into home-based caregiver training, public health messaging, and community care models. Such an approach not only honours local values but enhances the sustainability, acceptability, and effectiveness of mental health interventions in South African township settings.

2.5.2 Community-Based Organisations (CBOs) and Faith-Based Care

In the absence of adequate state support and mental health infrastructure, community-based organisations (CBOs), non-governmental organisations (NGOs), and faith-based institutions have emerged as indispensable actors in mental health care, particularly in under-resourced South African settings such as Clermont Township. These grassroots entities often act as the actual mental health system, offering both practical assistance and emotional support to overburdened home-based caregivers (Nguse & Wassenaar, 2021; Raphal, 2023).

Community-based organisations provide a range of vital services that partially offset the neglect by formal health systems. These typically include:

- Peer support groups for caregivers to share experiences and reduce isolation;
- Basic mental health literacy and caregiving training;
- Home visits and psychosocial counselling;
- Referral systems to link families with clinics and hospitals;
- Material support such as food parcels, toiletries, or transport fare for appointments.

These interventions, though often modest and underfunded, are lifelines in contexts where home-based caregivers operate with little to no external assistance. According to Mmereki and Molefi (2025), CBOs in peri-urban areas like Clermont serve as bridges between biomedical services and local cultural beliefs, helping caregivers navigate both systems simultaneously.

From a medical anthropology perspective, the value of these organisations lies not only in-service delivery but in their embeddedness in local moral worlds. CBOs are often staffed by community members who share the home-based caregivers' linguistic, cultural, and religious frames of reference. This allows for more culturally congruent care, enhancing trust and accessibility (Kirmayer & Pedersen, 2021).

Equally central to home-based caregiving in township communities are faith-based institutions, particularly churches, which often function as informal mental health providers. Pastors, lay ministers, and spiritual leaders are frequently approached before clinicians, especially in cases where illness is interpreted as spiritually or morally rooted (Monnapula-Mazabane & Petersen, 2023). Churches provide prayer, moral guidance, communal solidarity, and healing rituals, offering caregivers a way to understand and cope with suffering through spiritual frameworks.

However, faith-based care is not without complications. While some churches promote compassionate, inclusive attitudes toward mental illness, others perpetuate harmful beliefs, equating psychiatric symptoms with demonic possession, witchcraft, or punishment for sin. This has serious implications for both caregiver wellbeing and patient rights.

To address this tension, researchers and advocates argue for faith-sector engagement in mental health advocacy. Training spiritual leaders in basic mental health literacy, trauma-informed

counselling, and anti-stigma messaging can transform churches from spaces of judgment into critical allies in psychosocial care (Raphal, 2023). Collaborative interventions such as partnerships between clinics and faith institutions have shown promise in other African settings (Kaggwa et al., 2022; de Oliveira et al., 2022), particularly when they honour spiritual worldviews while introducing evidence-based practices.

In many under-resourced settings, community-based and faith-based responses to mental illness caregiving fill critical gaps left by weak or inadequate state support. CBOs offer culturally relevant, low-cost interventions that reduce caregiver isolation, while churches provide spiritual anchoring and moral support. However, both must be strategically supported, integrated, and regulated to avoid perpetuating stigma or misinformation.

From a policy perspective, engaging these grassroots actors in mental health care is not only cost-effective but essential for building locally trusted, culturally coherent mental health systems. By equipping faith leaders and CBO workers with accurate knowledge and counselling tools, South Africa can amplify existing community strengths while safeguarding caregiver and patient rights.

2.6 The Family as the Centre for Social Support

Research across diverse global contexts indicates that family caregivers of persons living with mental illness commonly experience overlapping challenges related to stigma, emotional burden and limited institutional support, although these experiences are shaped by local socio-economic and cultural conditions (Choudhry et al., 2023; Lund et al., 2022). Deinstitutionalisation has shifted the responsibility for long-term psychiatric care to households, leaving family home-based caregivers as the frontline mental health workforce, often unrecognised, trained, or uncompensated (Gamieldien et al., 2023).

Family home-based caregivers monitor medication adherence, manage crises, supervise daily functioning, and provide emotional support, all while juggling work, parenting, and household tasks (Nkosi, 2023). Many unpaid female relatives, like mothers, grandmothers, or sisters, are expected to care for their families, often due to gendered cultural norms that prioritise nurturing and sacrifice (Tronto, 2020). Families often face tough choices, like withdrawing children from school to save money for psychiatric hospital transport or neglecting their own health to care for a mentally ill relative. This causes role strain, emotional exhaustion, and social isolation,

especially in single-parent households or with multiple dependents (Florina & Babes-Bolyai, 2011; Rudnick, 2014).

Family support can reduce home-based caregiver burden, but it's not always harmonious. Stigma, blame, and fear can cause conflict, with one member (usually the eldest female) taking on the caregiving duties while others withdraw or reject the patient. In extreme cases, mental illness is seen as a curse that threatens family reputation, leading to neglect, abandonment, or confinement. Medical anthropology emphasises that family dynamics are shaped by power, gender, and cultural kinship norms. Understanding these dynamics is crucial for designing family-inclusive mental health interventions that consider familial harmony and caregiving willingness.

Educating families about mental illness, offering counselling, and providing financial or respite support reduces caregiver stress and improves patient outcomes (WHO, 2021; Cohen & Willis, 2018). Community-based support groups and psychoeducation programmes, co-led by mental health professionals, caregivers, and traditional healers, bridge biomedical and cultural understandings of illness and strengthen caregiving capacity. However, these initiatives are rare in township settings due to policy implementation gaps, transport barriers, and stigma. Institutionalising home-based caregiver support within South Africa's mental health system requires recognising families as partners in care.

Implications for Township Mental Health Care Contexts

In Clermont, families are the foundation of mental health care, but they're overstretched and under-supported, burdened with responsibilities that should be shared with formal health systems. To address this, we need to address the home-based caregiver burden.

- Enhancing family resilience through culturally appropriate education and support groups.
- Challenging gendered caregiving norms to redistribute care tasks within households.
- Incorporating family support policies into mental health frameworks to offer financial and psychosocial assistance.

Medical anthropology reframes families as both vulnerable and resourceful actors, central to healing ecosystems, whose well-being is intrinsically linked to patient recovery.

2.7 Theoretical Framework

This study is underpinned by three complementary theoretical perspectives: social constructionism, social identity theory, and feminist theory. These perspectives collectively provide a multidimensional analytical framework to examine the experiences and navigation of home-based caregivers in Clermont Township as they care for individuals diagnosed with mental illness. These frameworks are particularly pertinent within the field of medical anthropology, as they facilitate the exploration of how home-based caregiving not only constitutes a practical activity but also a culturally constructed, gendered, and socially embedded phenomenon. This phenomenon is shaped by power dynamics, the formation of identities, and local explanatory models of illness.

Social Constructionism

Social Constructionism suggests that reality, including health, illness, and caregiving, is shaped by language, culture, and social interactions (Hashemi & Mashinchi, 2020). From a medical anthropology perspective, this theory shows that mental illness is not a fixed concept, but is interpreted differently in different cultures, influenced by indigenous knowledge and local disease models (Bhugra et al., 2021).

In Clermont Township and many South African communities, mental illness is often seen as spiritual or cosmological, like witchcraft, ancestral displeasure, or moral wrongdoing (Monnapula-Mazabane & Petersen, 2021; Daniels et al., 2022). Cultural interpretations influence symptom recognition, perceived causality, and treatment choices, causing home caregivers to combine biomedical care with traditional healing practices (Campbell-Hall et al., 2020). Social Constructionism also shows how home-based caregiving is a socially constructed role influenced by gender, kinship, and socio-economic power. In low-income settings, it's usually feminised, underpaid or unpaid, and seen as women's moral duty (Ghaedi, Hadinezhad & Ahmadi, 2020). This theoretical lens encourages reflexivity, reminding researchers that knowledge is co-produced, and caregivers' meanings of their roles are fluid, negotiated, and contextually grounded (Fernando, Caplan & Haines, 2017; Nkomo & Kekana, 2024).

Social Identity Theory

Social Identity Theory (Tajfel & Turner, 1979) suggests that our self-concept is influenced by our membership in social groups. This theory offers insights into how home-based caregivers'

identities are shaped by their role, societal perceptions, and the stigma associated with mental illness in home-based caregiving settings (Brown, 2005; Onyia et al., 2024).

Medical anthropology views identity as socially constructed, shaped by historical inequalities, local hierarchies, and cultural norms of home-based caregiving. In South Africa, apartheid's legacy persists, influencing social divisions and healthcare access, and affecting how informal caregivers are perceived compared to professional healthcare workers (Nguse & Wassenaar, 2021). Home-based caregivers often face reduced legitimacy and recognition, and stigma towards mental illness leads to social marginalisation, blame, and exclusion. However, collective identity formation helps them find resilience by connecting with peers, fostering support networks, and sharing coping strategies (Gamielien et al., 2023). Social Identity Theory explains the fluid nature of home-based caregiving identities, showing how solidarity, training, and policy recognition can empower and renegotiate social status.

Feminist Theory

Feminist Theory examines the gendered aspects of home-based caregiving, highlighting structural inequalities and cultural expectations that disproportionately burden women (Tanwar, 2021; Crossman, 2020). Feminist medical anthropologists highlight how home-based caregiving intersects with race, class, and historical marginalisation, especially for Black women in South African townships who often provide unpaid, unacknowledged, and emotionally draining care labour (Silaule, Adams & Nkosi, 2024; Ndlovu & Mokwena, 2023).

Feminist theory critiques patriarchal, capitalist, and biomedical systems that invisibly undervalue women's home-based caregiving, while reinforcing their social obligation to care (Arinder, 2020). In Clermont, poverty, limited formal support, and societal norms that link womanhood to family well-being exacerbate the gendered burden. Feminist anthropology emphasises agency and resistance, showing how women caregivers negotiate, adapt, and challenge structural constraints, developing informal coping networks and alternative healing practices despite neglect and stigma (McDowell, 2003). This perspective understands home-based caregiving as a site of resilience, creativity, and political struggle, not just as a burden.

Integration of Theories

These three frameworks offer a comprehensive, interdisciplinary understanding of home-based caregiving in Clermont Township.

- Social Constructionism uncovers the cultural meanings and narratives of illness and care.
- Social Identity Theory explains how group affiliations and stigma influence home-based caregivers' self-concepts and social standing.
- Feminist Theory reveals the gendered power dynamics and systemic inequalities that shape caregiving roles.

This framework integrates medical anthropology's focus on culture, identity, power, and health, enabling a context-sensitive exploration of home-based caregivers' roles, mental illness interpretation, and coping strategies in an unequal health system.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction.

This chapter presents the methodological framework employed in this study on the lived experiences and coping strategies of home-based caregivers supporting relatives diagnosed with mental illness in Clermont Township, KwaZulu-Natal. This chapter outlines the research philosophy, design, study setting, participant selection, data collection methods, data analysis procedures, ethical considerations, and strategies used to ensure trustworthiness. The methodological choices adopted in this study were guided by the nature of the research problem and the aim of exploring caregivers' lived experiences in context.

In this chapter, we commence by delineating the interpretivist paradigm and phenomenological design that underpinned the inquiry. Subsequently, we engage in a discussion of the theoretical frameworks that influenced the analysis, namely Social Constructionism, Feminist Theory, and Social Identity Theory. The chapter then describes the study setting of Clermont Township, a community characterised by socio-economic vulnerability, cultural diversity, and restricted access to mental health services. Subsequently, we present the demographic profile of the participants and the sampling strategies employed.

The chapter proceeds to detail the multi-method approach to data collection, encompassing semi-structured interviews, participant observation, group discussions, and the utilisation of secondary sources. Furthermore, we elucidate the thematic analysis process applied to the data. Issues of trustworthiness, ethics, and reflexivity are addressed, along with a discussion of the study's limitations and the measures taken to address them.

This chapter provides the methodological basis for the study and explains how the research was conducted. The next section discusses the research philosophy and design that underpinned the study.

3.2 Research Philosophy and Design.

Research Philosophy is the foundation of scholarly work, defining valid knowledge and outlining methods for getting it. Ontology explores the concept of ‘realness,’ while epistemology examines how we acquire and understand it. These principles shape the types of inquiries and interpretations in social sciences (Creswell & Creswell, 2023). The selection of a research philosophy was guided by the study aim and the need to understand participants’ experiences within their social and cultural context.

Several traditions were considered but ultimately set aside. Positivism, grounded in observation and quantifiable data, has made significant contributions to the fields of epidemiology and clinical research. However, its emphasis on numerical data and broad generalisations diminishes its effectiveness in capturing the symbolic, spiritual, and emotional dimensions of township home-based caregiving. Post-positivism acknowledges bias but prioritises prediction and generalisation, making it better suited for large-scale health science than for anthropological research. Although other philosophical traditions were considered, they were not selected because they were less suited to the study’s emphasis on lived experience, meaning, and context.

Pragmatism values knowledge for practical use (Morgan, 2020). While flexible approaches risk reducing caregiving to a question of coping better, underplaying the cultural meanings caregivers emphasised. While these approaches offered insights, none aligned with the study’s focus on lived meanings and cultural logics.

The study adopted an interpretivist philosophy because it assumes reality is socially constructed through culture, interaction, and history, and knowledge comes from understanding meaning, not measuring facts (Thanh & Thanh, 2021).

Home-based caregivers in Clermont used hybrid logics to explain mental illness, combining biomedical ideas with ancestral displeasure, witchcraft, Ubuntu ethics, and Christian faith (Nguse & Wassenaar, 2021; Nxumalo & Mkhize, 2023). In this frame, such explanations are treated as valid knowledge systems, not dismissed as misconceptions. Home-based caregivers' accounts are analysed as meaningful frameworks, not judged against biomedical standards. This approach aligns with medical anthropology's emphasis on insider perspectives in understanding illness and care (Kirmayer & Pedersen, 2021). This approach allowed participants' own understandings and meanings to remain central to the study. Interpretivism also required ongoing reflexivity throughout the research process in order to remain attentive to how the researcher's position could shape data generation and interpretation.

This foundation allowed the study to employ a phenomenological design, which seeks to uncover how individuals interpret and make sense of their lived worlds. Phenomenology allowed home-based caregiving to be studied beyond a checklist of tasks, recognising its emotional, symbolic, and cultural significance (Hennink et al., 2020). A crucial principle here is bracketing, which involves suspending preconceptions to remain open to participants' accounts (Braun & Clarke, 2021). Within the phenomenological design, attention was given to preserving participants' meanings during transcription, translation, and analysis.

Phenomenology alone risks focusing on individual experience, neglecting collective and structural forces shaping home-based caregiving in poverty and stigma. To address this, the study embedded phenomenology in a theoretical framework. Social Constructionism showed how illness and care are negotiated through language, narratives, and practice. Feminist Theory revealed how women's unpaid caregiving is naturalised as a duty but invisible in wider social structures. Social Identity Theory analysed how caregiving reshaped women's sense of belonging, recognition, and stigma in families and communities (Nguse

& Wassenaar, 2021). Together, these frameworks extended the analysis beyond individual accounts, connecting them to wider cultural and structural dynamics.

The study drew on Social Constructionism, Feminist Theory, and Social Identity Theory as complementary analytical frameworks to support interpretation of the findings. Overall, the interpretivist paradigm, phenomenological design, and selected theoretical frameworks provided a coherent foundation for the study.

3.3 Study Setting and Participants.

This study was conducted in Clermont Township. Clermont, a township in KwaZulu-Natal, covers 6.94 km² and had a population of 52,075 in 2011, with a density of nearly 7,500 people per km². This figure likely increased due to ongoing urban migration. Unemployment remains high: KwaZulu-Natal's official unemployment rate was 30.7% in 2025, with an expanded definition of 43.3% (StatsSA, 2025). In Clermont, youth unemployment is over 58%, and over 40% of households live below the poverty line, making them vulnerable to mental illness (Rapiya et al., 2025).

Despite being close to Durban, access to specialist psychiatric facilities is limited and unequal in Clermont. The nearest hospitals are Town Hill Hospital (Pietermaritzburg, 70 km away), Fort Napier Hospital (Pietermaritzburg, 75 km away), RK Khan Hospital (Chatsworth, 22 km away, with a small psychiatric ward), and Addington Hospital (Durban CBD, 18 km away, with limited psychiatric services). Local clinics like KwaDabeka Clinic provide basic mental health support, but participants often face long waiting times, limited beds, and inadequate medication. South Africa has fewer than one psychiatrist per 100,000 people, with rural and township areas being the most underserved.

Figure 3.3. Map illustrating the distance between Clermont and nearby hospitals



Figure 3.3 shows Clermont's location near the nearest psychiatric hospitals. Clermont is red, and the four closest hospitals (Town Hill, Fort Napier, RK Khan, and Addington) are blue. Approximate travel routes and distances are indicated. The figure shows the geographic barriers home-based caregivers face in accessing specialist psychiatric services. RK Khan and Addington are closer, but their wards are small and under-resourced, limiting their capacity to serve the township. Town Hill and Fort Napier, which offer more comprehensive psychiatric care, are in Pietermaritzburg, over 70 km from Clermont. This distance makes it difficult for many households to access care. Despite Clermont's proximity to Durban, the community remains underserved. Local clinics like KwaDabeka provide basic mental health support, but participants described long queues, medication shortages, and inadequate facilities.

The figure situates Clermont's reliance on home-based care within broader systemic constraints, illustrating how uneven psychiatric service geography compounds household vulnerability. It strengthens the study's trustworthiness and transferability by visually representing the structural context of caregiving.

The figure complements thick description, allowing readers to better appreciate systemic challenges shaping participants' narratives. It illustrates physical distance and conveys the symbolic and structural marginality of township caregiving.

Clermont Township, situated within the eThekweni Metropolitan Municipality of KwaZulu-Natal, is a semi-urban community. Historically, it holds a significant place as one of the few areas where Black South Africans were permitted to acquire land during the apartheid era. Despite its resilience and independence, Clermont Township continues to grapple with structural inequalities. Today, it displays stark contrasts: some neighbourhoods are marked by formal housing and basic services, while others remain overcrowded, with informal settlements, fragile infrastructure, and limited access to healthcare. Home-based caregiving unfolded in this environment where historical legacies and present deprivation were closely entwined, creating conditions in which daily survival and long-term care were in constant tension.

Poverty and unemployment strained households, forcing trade-offs between immediate needs like food and schooling, and longer-term health needs. Despite being close to Durban, psychiatric facilities in Clermont are under-resourced and inadequate. As a result, households became the primary crisis management sites, providing care in unsuitable settings. This reliance on improvised family-based responses mirrors a national pattern where informal systems often replace absent formal provision. Home-based caregiving was influenced by cultural pluralism, beyond material constraints. Mental illness was understood through hybrid frameworks combining medical diagnoses with ancestral displeasure, witchcraft, and spiritual imbalance. Families pursued parallel strategies, combining biomedical services with prayer, rituals, or traditional consultations. This complexity requires an interpretivist and anthropological lens to capture home-

based caregiving as more than technical work, recognising its symbolic and spiritual dimensions.

3.4 Role of Key Informants

Key informants, like community health workers, church leaders, and neighbours familiar with the participants, bridged the gap between me and their households. Their social position and insider knowledge allowed me to access the township effectively, unlike if I had recruited participants independently.

Initial access to participants was facilitated through a gatekeeper and community-based key informants who assisted in identifying households that met the study criteria. Their role was limited to facilitating entry and introducing the researcher to potential participants in accordance with approved ethical procedures. Key informants assisted in preparing households for the researcher's visit and helped establish initial communication with potential participants. This facilitated respectful entry into the field and supported trust-building during recruitment.

In some cases, participants requested additional time before agreeing to participate. Follow-up visits were therefore conducted where necessary to ensure that consent remained voluntary and informed. Participants' willingness to engage with the study was supported by the use of locally recognised intermediaries and by the researcher's familiarity with the study setting. This contributed to rapport while maintaining formal ethical procedures.

The involvement of key informants supported recruitment by facilitating communication, access, and trust during the early stages of field entry.

Theoretical Reflection

Key informants were used primarily to facilitate access, identify eligible participants, and support the recruitment process within the community. Their

role was procedural rather than analytical and formed part of the study's field access strategy.

3.5 Gatekeepers and Access Negotiation

Ward councillors, civic leaders, and committee members played a crucial role in legitimising my presence in Clermont. Their blessing was essential for many participants to engage. In a society where, mental illness stigma and mistrust of outsiders coexist, gatekeepers acted as intermediaries, safeguarding participants and enhancing my credibility as a researcher.

I distinctly recall the day I attended a community meeting at the local hall. I had been invited to formally present my research to elders, ward representatives, and residents. Standing at the front, I introduced myself in isiZulu and meticulously explained the purpose of my study. The hall was hushed, with rows of chairs predominantly occupied by older men and women. Upon concluding my presentation, one elder raised his hand and inquired sharply, "Are you a native of this place? Will you return, or will you retain the knowledge and depart?"

In that silence, I felt the weight of history pressing upon me. Their inquiry extended beyond my individual circumstances, encompassing the researchers who had ventured into the township, gathered data, and subsequently vanished. At that juncture, I came to the profound realisation that my ethical obligations transcended mere informed consent forms; they encompassed the cultivation of enduring trust. I assured them I'd return with feedback, share my findings easily, and treat their stories with respect. My words were a methodological statement, but they felt like a moral commitment in that setting.

This experience taught me that access requires sincerity and accountability. In the weeks that followed, I noticed the impact of that meeting. Several home-based caregivers told me that community leaders had heard from me that I was different

from other researchers because I had introduced myself openly and promised to return. This endorsement from gatekeepers opened doors that might have otherwise remained closed.

Not all negotiations were smooth sailing. One civic leader initially declined to assist me, stating, “We have witnessed researchers arrive, acquire knowledge, and depart without leaving us with anything.” His scepticism served as a reminder that being local did not absolve me from suspicion. It required repeated visits, informal conversations, and transparency regarding my academic objectives before he reluctantly consented to introduce me to a few families. This hesitation instilled patience in me, but it also humbled me: access is not a right, but rather a privilege bestowed upon those who bear the trust of the community.

Theoretical Reflection

From a Social Constructionist perspective, these negotiations showed how research is socially shaped. Knowledge isn’t freely given; it’s constructed through relationships, legitimacy, and authority endorsement. Gatekeepers determined who was trustworthy and who could participate.

Feminist Theory helped me understand the gendered dynamics at play. Male leaders spoke in public, but women caregivers were the “real gatekeepers” to the stories I sought. Their willingness to speak was influenced by community hierarchies and relational negotiations of care and trust in their homes.

From a medical anthropological perspective, the process of negotiating access underscored the politics of representation. Communities shaped by histories of marginalisation have learned to be cautious about how their lives are narrated. The question “Will you return, or will you take the knowledge and leave?” highlighted the anthropological critique of extractive research, reminding me that gatekeeping was not only about protection but also about demanding reciprocity.

3.5.1 Building Rapport

Accessing key informants was the first step; building rapport with home-based caregivers was the deeper work. Rapport was cultivated through patience, cultural sensitivity, and consistent presence. Home-based caregivers needed time to assess my trustworthiness with their most painful experiences.

I quickly realised that rapport wasn't about formal introductions, but about the everyday rhythms of life. At home, my first visits often ended with tea, casual conversation, or even shared silence. These early encounters felt unproductive, but they were crucial for building trust.

One home-based caregiver, MaZulu, gently tested me by asking, “Wena uzokwazi yini ukubekezelela izindaba zethu ezinzima? Akulula, mntanami.” (“Will you be able to endure our heavy stories? It is not easy, my child.”). Her words were both a challenge and an invitation. I assured her that I was there to listen without judgment, and over the following weeks, she gradually opened up to me. By the time she agreed to a recorded interview, I had already visited her twice just for conversation. This process reminded me that research relationships are built over time, not demanded upon arrival.

Another vivid memory is of waiting outside a home-based caregiver's residence for several hours while she attended to her relative who was experiencing a challenging episode. I sat quietly, listening to the sounds of children playing and neighbours conversing, wondering if she would eventually have time for me. When she finally invited me in, she did not apologise for the delay; instead, she casually inquired if I was hungry and commenced preparing food. We ultimately conducted the “interview” in her kitchen while she cooked, her words interspersed between instructions to her children and stirring pots. It was at that moment that I realised that rapport was about meeting individuals in their own world, rather than expecting them to enter mine.

In another instance, a home-based caregiver insisted on knowing about my family before she would share information about hers. She directly inquired, “Ubani okunakekelayo ekhaya lakho?” (“Who takes care of you at your home?”). Initially, I hesitated, but then I understood that this was her way of setting up a balanced exchange. By sharing some of my own experiences, I proved that my purpose was not solely to obtain information but to engage in a reciprocal human connection. This moment blurred the boundaries between researcher and participant, reminding me that trust necessitates vulnerability from both parties.

Building rapport was also achieved through subtle acts of cultural familiarity. Speaking isiZulu, employing local idioms, and demonstrating respect for elders helped position me not as an outsider but as an individual who comprehended community dynamics. In one household, a home-based caregiver expressed relief when I addressed her as “Mama” instead of by her first name. She subsequently informed me, “Uma ungazisa kahle abantu, bayakwazi ukukhuluma nawe.” (“If you show respect when introducing yourself, people will be able to engage in conversation with you.”). These instances underscored the pivotal role of cultural etiquette in fostering trust.

Theoretical Reflection

From a social constructionist perspective, rapport-building underscores that knowledge is co-constructed through relationships. Home-based caregivers were not passive subjects; they actively shaped the conditions under which they were willing to share their experiences. Often, they needed patience, respect, and reciprocity before allowing their voices to be recorded.

Feminist theory emphasised the significance of personal connection, emotional labour, and shared vulnerability in the context of care. Many home-based caregivers expected me to prove not only intellectual understanding but also emotional empathy towards their burdens. Their insistence on relational

exchange, asking about my own family and inviting me into their kitchens, revealed the deeply embodied and gendered ways in which trust was negotiated.

From a Medical Anthropology perspective, rapport was shaped by home-based caregiving. Interviews often happened in kitchens, on verandas, or while participants cared for relatives, highlighting the intertwining of mental illness and caregiving in daily life. Building rapport involved respecting these spaces and accepting that research would adapt to caregiving rhythms rather than the other way around.

3.5.2 Recruitment Challenges

Despite the support of key informants and gatekeepers, the recruitment process encountered several challenges. These challenges often underscore the delicate social environment in which mental illness is situated in Clermont, where stigma, silence, and conflicting responsibilities influence the decision-making processes of caregivers regarding their participation.

Stigma was the biggest challenge. Mental illness is still highly stigmatised in the community, and some families fear gossip. After the councillor's assistant introduced me, a home-based caregiver agreed to be interviewed. But when I returned, she refused to open the gate. She said softly, "People will think we are all mad if I talk to you." I felt disappointed and helpless, but I understood her fear. Speaking out could risk social labelling that would harm her family. That moment taught me that recruitment is not just about access, but also about negotiating silence due to stigma.

Another significant challenge was the imposition of time constraints. The daily lives of home-based caregivers were inherently unpredictable, influenced by the rhythms of caregiving, informal work, and household responsibilities. On certain days, I found myself spending hours outside a home, only to be informed at dusk

that the caregiver had been overwhelmed or emotionally drained to engage in conversation. Initially, these delays were frustrating, but over time, I gradually came to perceive them as inherent characteristics of the research context. Caregiving does not cease for research purposes. One participant succinctly expressed this sentiment: “Umsebenzi wethu awupheli, ngisho uma sifuna ukukhuluma nawe.” (“Our work never ceases, even if we desire to communicate with you.”). Their time constraints were not indicative of a rejection of my research efforts but rather a reflection of the constant demands that were placed upon them.

There were also moments of gatekeeping fatigue. Some community leaders expressed reluctance to support my work due to previous experiences with researchers who had come, collected data, and left without sharing their findings. One ward representative directly stated, “Sike sabona abacwaningi beza, bathathe ulwazi, basishiya nendlala.” (“We have seen researchers come, take knowledge, and leave us with nothing.”) His words resonated deeply because they reflected a broader sentiment within the community that research often feels extractive. Earning his trust necessitated repeated visits, open dialogues, and assurances that I would share my findings with the community.

In conclusion, the challenge of positionality arose. While some participants welcomed me warmly because I was a “child of this place,” others were more sceptical, believing that being local implied that I already comprehended their struggles and did not necessitate further inquiries. One caregiver, in a lighthearted manner, remarked, “Awudingi ukufunda ngalokhu, ngoba siyafana.” (“You don’t need to study this, because we are the same.”) Her words prompted me to contemplate the intricate nature of being both an insider and an outsider, close enough to be trusted yet sometimes too close to be taken seriously as a researcher. Balancing these identities was emotionally taxing, as I continually grappled with the question of whether my presence felt supportive or intrusive.

Theoretical Reflection

From a Social Constructionist lens, these challenges highlight how access to knowledge is socially negotiated and constrained. Silence, refusal, or withdrawal were not simply barriers but active ways in which participants shaped what could be known and by whom.

Through Feminist Theory, the time constraints and emotional exhaustion of home-based caregivers underscore how the burden of care falls disproportionately on women. Their limited availability for interviews was not a methodological inconvenience but a reflection of the structural invisibility of women's labour, which continues even when researchers arrive at their doors.

From a Medical Anthropology perspective, stigma itself became a powerful ethnographic finding. The reluctance to be associated with mental illness illustrated how illness is not just a biomedical category but a cultural identity marker that families seek to avoid. The challenge of recruitment, therefore, mirrored the challenge caregivers themselves face negotiating visibility and silence in a community where mental illness is heavily stigmatised.

3.6 Sampling Approach

This study employed purposive sampling, a non-probability sampling strategy commonly used in qualitative research to select participants with direct experience of the phenomenon under investigation (Creswell & Poth, 2018). Participants were recruited through community networks and referrals from local health structures in Clermont Township. The inclusion criteria required participants to be adult home-based caregivers who were actively involved in providing care for individuals diagnosed with mental illness within the community. Purposive sampling enabled the researcher to engage participants who possessed rich experiential knowledge of caregiving practices, household

dynamics, and the everyday challenges associated with supporting persons living with mental illness.

This approach was appropriate because it enabled the selection of participants with direct experience of home-based caregiving for persons living with mental illness. Recruitment through trusted community networks and local health structures assisted in identifying participants who met the study's inclusion criteria and were able to provide relevant information aligned with the research objectives.

Recruitment was facilitated through gatekeepers and key informants who assisted in identifying potential participants who met the study criteria. Participation remained voluntary, and only individuals who agreed to take part after the study had been explained were included. Trust-building formed part of the recruitment process to ensure informed and comfortable participation.

Purposive sampling aligned with the interpretivist orientation of the study, which prioritised depth of understanding and the selection of information-rich participants. This approach supported the generation of detailed accounts relevant to the cultural, social, and caregiving contexts under investigation.

Purposive sampling also enabled the inclusion of participants with varied caregiving roles and experiences. This included differences in caregiving intensity, household responsibilities, and care-seeking pathways, thereby broadening the range of perspectives represented in the sample.

Participants were selected according to predefined inclusion criteria, including residence in Clermont Township, at least one year of caregiving experience, and active involvement in caring for a relative diagnosed biomedically or ethnomedically. During recruitment, caregiving roles were clarified through

discussion to determine whether individuals met the study requirements. Purposive sampling enabled the study to recruit participants who were directly involved in home-based mental health caregiving and who could provide detailed accounts relevant to the study objectives. This contributed to the collection of rich qualitative data on caregiving experiences and coping practices.

3.6.1 Participants

A total of twenty participants were recruited for this study. The determination of sample size was guided by the principle of thematic saturation, which refers to the point at which no novel themes, patterns, or insights appear despite conducting additional interviews (Hennink & Kaiser, 2022). Saturation is not solely dependent on the quantity of participants but rather on the depth of comprehension, ensuring that the data collected adequately captures the complexity of participants' lived experiences.

By the eighteenth interview, recurrent patterns had begun to emerge across participant accounts. Two additional interviews were conducted to confirm thematic repetition and ensure adequate coverage of the study objectives. After the twentieth interview, no substantially new themes were identified, indicating that thematic saturation had been reached. The final sample size of twenty participants reflected both the principle of thematic saturation and practical fieldwork considerations, including participants' availability and caregiving responsibilities. This number was considered sufficient to generate in-depth qualitative data while remaining manageable within the study context.

The sample size was also appropriate for the interpretivist and phenomenological design of the study, which prioritises depth of understanding over numerical breadth. Interviews ranging between one and two hours generated detailed

accounts that were further supported by field notes and follow-up engagement where necessary.

The determination of saturation was based on repeated recurrence of themes across interviews rather than on a fixed numerical target. Later interviews largely confirmed existing patterns already identified in earlier accounts.

Why Only Female Participants?

All participants in this study were female home-based caregivers. This was not a deliberate design choice at the outset, but rather a reflection of the sociocultural home-based caregiving patterns in Clermont Township. During recruitment, key informants and gatekeepers consistently directed me towards mothers, sisters, and aunts as the primary caregivers of relatives with mental illness. When I inquired about male relatives, I was often told: “Ubaba usemsebenzini” (“The father is at work”) or “Amadoda awanandaba” (“Men are not concerned with this”). Men were described as present in households but largely absent from the daily, intimate labour of home-based caregiving. At best, they contributed financially or occasionally transported relatives to clinics.

During recruitment and household visits, women were consistently identified as the primary caregivers of relatives living with mental illness. Male household members were present in some homes but were not identified as being primarily responsible for day-to-day caregiving tasks. The absence of men as active participants underscores broader cultural and structural expectations in South Africa, where caregiving responsibilities within families have traditionally been given to women. Scholars have found this phenomenon as the feminisation of care work, a situation where unpaid, emotionally taxing, and undervalued care is unevenly borne by women (Chitindingu & Mkhize, 2021; Mathanjana, 2024). In township settings such as Clermont, where households are often female-headed and resources are limited, this feminisation becomes even more pronounced.

The all-female sample reflected the caregiving patterns identified during recruitment in Clermont Township, where women were consistently identified as primary caregivers. This composition was therefore retained as an accurate representation of the accessible caregiving population within the study setting.

Interviews with female participants provided consistent information on the distribution of caregiving responsibilities within households and confirmed the predominance of women in daily mental health caregiving roles in the study setting. The all-female participant base therefore reflected the recruitment outcomes and the caregiving realities observed within the study setting.

Duration of Caregiving

Participants had to have been caregiving for at least one year. This criterion was adopted to ensure that participants had a sustained, lived experience of the role and had encountered the broad spectrum of caregiving demands, emotional, financial, social, and physical. Home-based caregivers with less than one year of experience were excluded, as they might still be adjusting to the initial shock of diagnosis and had not yet developed long-term coping practices or strategies.

The one-year threshold was used to ensure that participants had sufficient caregiving experience to reflect on established routines, responsibilities, and coping practices over time. From a practical standpoint, this criterion contributed to the assurance of data quality and depth. Home-based caregivers who had kept their role for a year or more were able to provide detailed accounts of challenges such as managing medication adherence, navigating hospital visits, or responding to episodes of relapse. They could also offer insights into long-term emotional and social consequences, including stigma, isolation, or strained family relationships.

This criterion helped distinguish between early adjustment to diagnosis and more sustained caregiving experience, thereby improving the relevance and depth of participant accounts for the purposes of the study.

The criterion also supported ethical sensitivity by limiting participation to individuals who had moved beyond the earliest adjustment phase of caregiving. Including participants with at least one year of experience supported the study's aim of examining sustained caregiving practices rather than immediate short-term responses to diagnosis. Participants with extended caregiving experience were able to provide detailed accounts of long-term caregiving responsibilities, role adaptation, and coping practices.

Biomedical and Ethnomedical Diagnosis

Participants were included if their relatives had received either biomedical or ethnomedical diagnoses. Biomedical diagnoses are obtained through psychiatric clinics, hospitals, or general practitioners, while ethnomedical diagnoses are obtained through traditional healers, diviners, or spiritual authorities. This decision was informed by the reality that Clermont, like many South African townships, is characterised by medical pluralism the coexistence and interaction of multiple healing systems. Families often navigate fluidly between biomedical and traditional explanations of illness, drawing on whichever framework feels most accessible, affordable, or culturally resonant at a given time.

Including both biomedical and ethnomedical diagnoses ensured that the study reflected the pluralistic care pathways present within the study setting, where families may engage multiple systems of explanation and treatment.

The inclusion of both diagnostic pathways broadened the scope of participant eligibility and ensured that caregiving experiences were captured across different illness explanatory models relevant to the local context.

This decision was also methodologically appropriate because it accommodated the explanatory diversity through which mental illness is identified and managed within the community.

Fieldwork indicated that participants drew on both biomedical and ethnomedical understandings when describing relatives' diagnoses and treatment pathways. This supported the inclusion of both categories within the sampling criteria. The coexistence of biomedical and ethnomedical diagnoses reflected the pluralistic health environment within which caregiving occurred in the study setting. The inclusion of both biomedical and ethnomedical diagnoses ensured that participant selection reflected the range of diagnostic pathways relevant to caregiving in the local context.

3.6.2 Inclusion and Exclusion Criteria

Defining inclusion and exclusion criteria was crucial to ensure the study sample aligned with the research aim of exploring the lived experiences and coping practices of home-based caregivers of persons with mental illness in Clermont Township. These criteria helped identify relevant participants while protecting those who might have been harmed by participation.

Inclusion Criteria

- Residing in Clermont Township

To maintain a grounded study, participants were required to reside in Clermont. This geographical and social context was characterised by Clermont's unique history as a semi-urban township, shaped by poverty, unemployment, and cultural pluralism. The setting provided the appropriate environment for exploring caregiving experiences.

- Primary or secondary caregiver (full-time or part-time)

Caregiving roles are often shared within families, so full-time home-based caregivers were included to reflect the fluid and collective nature of care in township households.

- At least one year of home-based caregiving experience

Participants had enough time to engage with the long-term challenges and coping strategies of home-based caregiving. Short-term caregiving experience was excluded as participants might still be adjusting to the diagnosis shock without developing adaptive practices.

- Relative diagnosed biomedically or ethnomedically

Home-based caregivers were included in the community's medical pluralism, regardless of whether their relatives were diagnosed by psychiatrists or traditional healers. This ensured a holistic understanding of caregiving experiences, reflecting local explanatory models of illness.

- Aged 20 years to 60 years old.
- Adult participants were recruited in order to ensure capacity for informed consent and to capture mature caregiving experiences. In the study setting, adult women were most commonly identified as primary providers of household-based care, although younger family members occasionally helped.
- Willingness to provide informed consent
- Informed consent was a mandatory requirement for participation. Participants were required to understand the purpose of the study, the voluntary nature of participation, and the measures in place to protect confidentiality and anonymity. Only individuals who provided informed consent were included.

Exclusion Criteria

- Home-based caregiving for less than one year

Excluding those with less than a year of experience ensured that the early adjustment phase of caregiving was not overrepresented, which might not reflect the sustained coping practices central to the study.

- Caring for conditions unrelated to mental illness

Caregivers supporting relatives with physical or chronic conditions (e.g., diabetes, HIV, disability) were excluded, as their experiences differ from those of mental illness caregivers, especially regarding stigma and cultural interpretations.

- Professional or paid home-based caregivers (nurses, social workers)

The study focused specifically on unpaid caregiving conducted within family and household contexts. Professional caregivers were excluded because their roles, motivations, and coping practices are shaped by formal training, employment obligations, and institutional support structures rather than familial responsibility.

- Male home-based caregivers

During recruitment, men were not identified as primary caregivers within the accessible participant networks. Where present, male family members were generally described as providing financial support or as being minimally involved in day-to-day caregiving. Their exclusion therefore reflected the caregiving patterns observed in the study setting rather than researcher-imposed bias.

- Individuals unwilling or unable to provide consent

Participant autonomy was central to the study's ethical approach. Only individuals who were willing and able to provide informed consent were included.

3.9 Reflexive Note

In practice, the application of inclusion and exclusion criteria required clarification during recruitment because caregiving roles varied across households. During recruitment, some participants initially described their roles in limited terms, but further discussion clarified the extent of their caregiving responsibilities. This required careful assessment to determine whether they met the study criteria. Diagnostic categories also overlapped in some cases, with participants describing both biomedical and ethnomedical explanations of illness. This reinforced the relevance of including both categories within the study criteria.

These variations required methodological flexibility while remaining consistent with the overall study criteria. This reflexive awareness informed the recruitment process by supporting careful clarification of participant roles and eligibility during sampling. Overall, reflexivity assisted in applying the sampling framework in a manner that remained responsive to the practical realities of recruitment while preserving methodological consistency.

The following table presents a demographic overview of the participants included in the study. It provides contextual information relating to age, kinship role, and caregiving background, thereby situating the qualitative accounts that follow within the profile of the 20 women who constituted the study sample.

Demographic Details of Participants

Participant (Pseudonym)	Abbreviation	Sex	Relationship to Person with Mental Illness	Age
MaZulu	P1	F	Mother	58
Mamnisi	P2	F	Sister	35
Zandile	P3	F	Aunt	47
MaNtuli	P4	F	Cousin	39
Sthabile	P5	F	Mother	37
Zanele	P6	F	Mother	28
Sindi	P7	F	Ex-Wife	48
Sthabile	P8	F	Aunt	45
Athini	P9	F	Mother	35
Uyivile	P10	F	Sister	29
Liyema	P11	F	Mother	60
Candice	P12	F	Mother	60
Nonhlanhla	P13	F	Aunt	52

Participant (Pseudonym)	Abbreviation	Sex	Relationship to Person with Mental Illness	Age
Manzuza	P14	F	Step-mother	50
Mabanga	P15	F	Mother	40
Thabisile	P16	F	Sister	25
Conny	P17	F	Sister	30
Olwethu	P18	F	Mother	25
Sane	P19	F	Mother	55
Ntokozo	P20	F	Mother	

Table 3.9.1 presents the demographic profile of the study participants. All 20 participants were female caregivers. In terms of kinship roles, the sample included mothers (10), sisters (5), aunts (3), as well as step-mothers, cousins, and ex-wives. Participants ranged in age from 20 to 60 years, with representation across younger, middle-aged, and older adult groups. This age range contributed to variation in caregiving experience within the sample. The sample included a range of caregiving relationships, allowing for representation of different kinship positions within family-based care. Overall, the sample reflected variation in age and kinship role among female caregivers within the study setting.

3.7. Data Collection Methods.

Qualitative research, a cornerstone of anthropology, explores how everyday practices, rituals, and meanings shape human experience (Erickson & Murphy, 2021). Within medical anthropology, qualitative research is particularly useful for examining community interpretations of illness, the organisation of family care, and the cultural and spiritual frameworks that shape healing and coping processes (White, 2022). In Clermont Township, home-based caregiving transcended clinical tasks and was deeply intertwined with Ubuntu ethics, kinship obligations, and religious convictions. Mental illness in many African contexts is frequently interpreted through spiritual, ancestral or supernatural frameworks, reflecting pluralistic belief systems that coexist with biomedical understandings of mental health (Ae-Ngibise et al., 2020; Campbell & Burgess, 2022).

The strength of this orientation lies in its capacity to generate rich contextual understanding. Qualitative methods show the layered and symbolic aspects of daily life (Nowell et al., 2022). In this study, qualitative methods made visible the ways in which home-based caregivers drew on hybrid explanatory models involving ancestral displeasure, witchcraft, Christian faith, and biomedical diagnoses, while simultaneously navigating the stigma and structural neglect associated with mental health care. These methods have also successfully captured silences, gestures, and embodied practices that often remain imperceptible in quantitative accounts. The researcher's flexibility allowed them to follow participants' worldviews and respond to emerging themes, which is crucial in contexts where cultural logics differ significantly from biomedical models (Kirmayer & Pedersen, 2021).

Central to this approach is the emic perspective, which prioritises participants' own categories, meanings, and language. For home-based caregivers in Clermont, illness was often understood not only as a medical condition but also as a spiritual

and moral challenge. As one caregiver observed, “Engaging in discussions about these matters in isiZulu facilitates the process, as English sometimes fails to adequately convey the depth of our emotions.” These emic accounts were pivotal in capturing home-based caregiving as it is experienced and interpreted, rather than merely performed. To operationalise this orientation, the study employed a multifaceted approach that integrated semi-structured interviews, participant observation, group discussions, and the utilisation of secondary sources.

3.7.1 Individual Interviews

Semi-structured interviews, guided by flexible open-ended questions, captured participants’ lived experiences and unexpected themes in this study (DeJonckheere & Vaughn, 2021). In this research, home-based caregivers were provided with the opportunity to express their experiences in their preferred language, whether it was isiZulu or English. These interviews often generated narrative accounts that combined descriptions of daily routines, coping practices, and cultural reflections. The flexibility of the method facilitated the emergence of themes such as church-based stigma, financial strain, and shifting kinship obligations. Interviews were conducted primarily in participants’ homes and generally lasted between sixty and ninety minutes.

These familiar environments fostered openness and situated participants’ accounts within the everyday rhythms of household life.

In addition to focus group participants, key informant interviews were conducted with individuals possessing specialised knowledge of mental health care within the community, including community health workers and individuals involved in local caregiving support initiatives. Key informants provided broader insights into the structural and institutional context of mental health care in Clermont, including challenges related to service accessibility, community perceptions of mental illness, and the support systems available to caregivers.

Pros and Cons of Semi-Structured Interviews

- **Advantages**
 - **Flexibility:** Caregivers can discuss important issues while ensuring research objectives are met, thanks to this approach that balances consistency with openness (Hennink et al., 2020).
 - **Depth:** They encourage detailed, narrative-style responses about cultural and emotional experiences.
 - **Cultural sensitivity:** Participants could express culturally embedded idioms and meanings using isiZulu or English.
- **Disadvantages**
 - **Time-consuming:** The interview process and subsequent transcription and analysis took a lot of time and money.
 - **Requires skill:** The interviewer's ability to probe sensitively, manage emotions, and adapt to each participant's context greatly influenced the quality of data (Rahi, 2023).
 - **Potential for bias:** Careful management is needed to avoid interviewer influence from flexibility.

My perspective as an interviewer was shaped by my dual role as an insider sharing cultural background, language, and community familiarity with participants and an academic researcher trained in medical anthropology. This dual role presented both benefits and challenges. On the one hand, cultural and linguistic familiarity fostered rapport, trust, and comfort, enabling participants to openly discuss sensitive topics such as stigma, caregiving responsibilities, and spiritual coping.

On the other hand, I was mindful of avoiding assumptions and consistently sought clarification to ensure participants' perspectives were accurately represented rather than influenced by my own assumptions.

The interpretivist and anthropological orientation of the study further shaped the interview process by directing attention to local explanatory models of mental illness, diverse health-seeking practices, and the symbolic significance of caregiving roles within township households. This perspective ensured that both the personal and socio-cultural aspects of caregiving were prominently featured in the interviews.

The interview process was both intellectually engaging and emotionally demanding. Conducting interviews in caregivers' homes enabled observation of care work within the context of everyday family life, including interruptions, domestic activity, and visible strain within overcrowded households. These contexts enriched the data and provided additional insight into the burdens carried by participants.

Establishing rapport required empathy, attentive listening, and sensitivity to silence and emotional expression. The use of isiZulu fostered a deeper level of trust, as participants were able to express culturally embedded idioms such as *idliso* and *ukuphambana* with greater precision and comfort. The researcher's insider position facilitated openness, while also requiring ongoing reflexive awareness of emotional involvement in participants' narratives. To maintain rigour, I documented my reflections after each interview, noting how my position, emotions, and assumptions influenced the interaction. This process ensured the caregivers' voices remained central, while acknowledging my interpretive role in knowledge production.

Advantages and disadvantages of Semi-Structured Interviews

Advantages

- Flexibility: Strikes a balance between structure and openness, ensuring research objectives are covered while allowing unexpected themes (Hennink et al., 2020).
- Depth: Allows participants to share their stories in isiZulu or English, encouraging narrative-style responses.
- Cultural Sensitivity: Enables the expression of local idioms and metaphors, reflecting cultural models of illness and care.
- Contextual Richness: Interviews conducted in participants' homes were grounded in the realities of daily caregiving.

Disadvantages

- Time-Intensive: Both conducting and analysing interviews required substantial resources.
- Skill-Dependent: The quality of the data was heavily reliant upon the interviewer's ability to conduct sensitive probing and manage their own emotions (Rahi, 2023).
- Potential Bias: Interviewers may exert influence if interviewees are not mindful of their reflexivity.
- Emotional Strain: Listening to distressing narratives placed emotional demands on both participant and interviewer.

The interviewer's perspective was influenced by a dual role: serving as both an insider with cultural and linguistic familiarity with participants and an academic researcher trained in medical anthropology. This positionality afforded advantages such as facilitating easier rapport-building, trust, and openness,

particularly when interviews were conducted in isiZulu. It enabled participants to share idioms and culturally embedded concepts such as idliso or ukuphambana without any constraints.

Simultaneously, I remained cognizant of the potential for cultural familiarity to engender assumptions of shared meaning. To mitigate this risk, I employed probing inquiries and attentive listening to guarantee the clarity and genuineness of participants' accounts. My anthropological lens emphasised the significance of cultural logics, the diversity of health-seeking behaviours, and the symbolic resonance of caregiving. This approach ensured that both socio-cultural and personal dimensions were comprehensively captured.

Participant observation was conducted as a complementary data collection method to enrich the interview and focus group material by documenting caregiving practices within naturally occurring community settings. Observation took place in contexts where home-based caregiving could be indirectly or directly witnessed, including caregiver support meetings, prayer circles, clinic waiting areas, informal household visits, and community gatherings where participants discussed or enacted caregiving responsibilities. The researcher adopted an overt observer-as-participant role, meaning that participants were aware of the researcher's presence and the purpose of the study, while observation remained focused on understanding the social and cultural context of care rather than participating in caregiving activities. Attention was given to verbal interactions, non-verbal communication, emotional expressions, household routines, gendered divisions of responsibility, and the ways in which stigma, support, and illness meanings were expressed in everyday practice. Field notes were written during observation where appropriate and expanded immediately afterwards to document the setting, persons present, key interactions, observed behaviours, contextual reflections, and methodological impressions. These notes formed part of the broader audit trail and were used to support data triangulation,

deepen contextual understanding, and strengthen the interpretation of caregiving as both a lived and socially embedded practice.

The duration and frequency of participant observation depended on the availability of participants and the accessibility of relevant community settings during fieldwork. Observation was not limited to formal events but also included naturally occurring moments before and after interviews, such as interactions among family members, caregiving interruptions during conversations, prayer practices, and discussions with neighbours or support group members. In each setting, the researcher remained attentive to the ethical boundaries of observation, particularly where emotional distress, privacy, or household vulnerability were evident. No covert observation was undertaken, and participants were reminded that the researcher's role was to observe social processes relevant to caregiving rather than to evaluate their personal conduct. This procedure enabled the study to capture dimensions of care that might not have been fully articulated in interviews, including silence, hesitation, relational tension, mutual support, and the embodied realities of caregiving within constrained material conditions.

Emotionally, the interviews were emotionally taxing. Home-based caregivers often recounted distressing experiences, moments of stigma, or exhaustion, occasionally expressing tears or prolonged silences. As an interviewer, I responded with empathy and compassion, ensuring that participants did not feel compelled to disclose more than they desired. Simultaneously, participant observation heightened my awareness of resilient atmospheres, such as shared laughter during meals or collective strength in church gatherings that might otherwise have gone unnoticed.

Reflexivity was key throughout the process. I kept a fieldwork diary to record observations, emotions, positionality, and potential biases. This helped balance my insider identity with analytical distance, ensuring I remained rigorous in

interpreting and presenting caregivers' experiences (Bertram & Christiansen, 2022).

3.7.2. Group Discussion Interviews

In addition to individual and participant observation interviews, group discussions were employed to capture the collective dimensions of home-based caregiving. Group discussions, or focus group interviews, involve a small group of participants reflecting collectively on their experiences, facilitated by a researcher (Krueger & Casey, 2021).

Two focus group discussions were conducted in order to elicit collective reflections on caregiving experiences.

. Each focus group consisted of six participants, resulting in a total of twelve caregiver participants involved in the study. Focus groups were utilised to capture shared narratives, community perspectives, and collective understandings of caregiving responsibilities within households affected by mental illness. The group format facilitated interaction among participants, enabling caregivers to respond to and build upon one another's experiences, thereby generating deeper insight into the social dynamics surrounding caregiving.

Each session had a duration of between ninety minutes and two hours, contingent upon the participants' availability and household obligations. Settings that were already familiar and perceived as trustworthy were deliberately selected in order to minimise discomfort and foster openness. The group setting fostered a shared sense of solidarity among participants.

The group setting fostered a shared sense of solidarity among participants. These sessions also unveiled generational patterns, as older women tended to facilitate the discussions while younger women deferred, reflecting broader kinship hierarchies within society.

Nevertheless, group discussions also presented several challenges. Time constraints were a recurring issue, as caregiving duties frequently clashed with the duration of the sessions, resulting in interruptions or premature departures. Furthermore, some participants expressed inquiries regarding compensation, reflecting the economic vulnerability of caregivers. Although it was clarified that the research was voluntary and non-remunerated, refreshments and transportation assistance were provided to recognise participants' contributions and alleviate participation burdens.

As an interviewer, my perspective was influenced by my dual role as an insider sharing cultural and linguistic familiarity with participants and an academic researcher. In group settings, this dual role fostered trust and comfort, particularly within prayer circles where shared cultural and spiritual knowledge facilitated open discussions. My insider status encouraged participants to candidly discuss caregiving challenges, stigma, and strategies, while my anthropological training guided me to delve deeper into the meanings and observe group dynamics critically. However, being an insider also presented risks of assuming shared understanding. To address this, I consciously posed clarifying questions and encouraged quieter participants to contribute, ensuring that group discussions did not inadvertently reproduce hierarchies of age or authority.

Facilitating group discussions was a complex but methodologically valuable process. On a practical level, I managed time pressures, as caregivers' responsibilities often led to late arrivals, early departures, or distractions during sessions. In some instances, participants raised questions about remuneration, underscoring the economic vulnerability of caregivers. While I provided refreshments and transport stipends to support participation, I clarified that the research itself was voluntary. Group discussions were also emotionally significant. Observing participants exchange support and coping strategies reinforced the collective dimension of caregiving practice. Nevertheless, silences occasionally

carried weight, indicating discomfort or fatigue that required careful facilitation and sensitivity to nonverbal cues.

As facilitator, the researcher observed that older women tended to dominate discussion, while younger caregivers were more likely to defer. I gently redirected the conversation, inviting quieter voices, to ensure inclusivity. This balanced respecting cultural norms with data collection.

My insider status as a Zulu-speaking woman from KwaZulu-Natal fostered trust and familiarity, allowing participants to share deeply personal and culturally embedded accounts. However, it also risked assuming shared understanding, so I consistently probed for clarification. For instance, when a caregiver said “uyaphambana” (“he is going mad”), I asked her to describe the behaviours associated with that phrase, avoiding a biomedical equivalence.

The fieldwork process was emotionally demanding. During one interview, a participant, the sole caregiver of her mentally ill son, became tearful, expressing loneliness and asking God if He had forgotten her. I allowed silence to linger, resisting the urge to fill it, and only continued once she signalled readiness. These experiences indicated that silence often carried emotional and symbolic significance within the interview process. Group discussions revealed my own positionality. Listening to caregivers describe their experiences of stigma and poverty reinforced the emotional demands of the research process. One participant said, “I thought I was alone, but now I see we’re many.” As an insider, I felt solidarity, but as a researcher, I documented not only spoken words but also hesitations, silences, and younger women’s deference to elders.

Secondary sources

In conclusion, secondary sources such as policy documents, non-governmental organisation (NGO) reports, and academic studies were consulted to contextualise participants’ testimonies within broader structural frameworks.

These materials highlighted the systemic underfunding of psychiatric services and the deficiencies in community-based provision (Petersen et al., 2022; World Health Organisation (WHO), 2023). Their utilisation was not intended to prematurely interpret findings but rather to provide the requisite background information, thereby ensuring that participants' voices could subsequently be comprehended in relation to the realities of service provision in South Africa.

These methods provided complementary insights. Interviews offered personal accounts; participant observation highlighted embodied practices; group discussions revealed collective perspectives; and secondary sources supplied structural context. Their integration created a layered, triangulated understanding of home-based caregiving as spoken, enacted, and situated within broader inequalities. This approach aligned with the study's interpretivist and phenomenological orientation and reflected medical anthropology's commitment to thick description: culturally grounded, ethically sensitive, and attentive to the moral and symbolic dimensions of everyday care.

The data collection process was iterative and, in some cases, required repeated engagement with participants. Follow-up interviews were conducted where initial interviews were interrupted by caregiving responsibilities, where participants later wished to elaborate on sensitive experiences, or where clarification was needed on emerging themes. These repeated encounters strengthened the depth and credibility of the data by allowing participants to expand on earlier accounts and by enabling the researcher to verify contextual detail across different interactions. Field notes were used throughout this process to document interruptions, observation contexts, methodological decisions, and reflections relevant to ongoing data generation.

3.8. Data Analysis

Data were analysed using thematic analysis following the procedures outlined by Braun and Clarke (2006). Interviews and focus group discussions were

transcribed verbatim to ensure familiarity with the data. An initial coding process was undertaken to identify meaningful segments relating to caregiving experiences, emotional labour, stigma, and support systems. Codes were then grouped into broader themes reflecting recurring patterns across participants' narratives. These themes were subsequently interpreted in relation to the theoretical framework of the study to understand how caregiving practices are shaped by gendered expectations, social identities, and structural conditions.

3.8.1 Thematic Analysis

Braun and Clarke (2021) outline six iterative phases of thematic analysis, which structured this study:

Data generated from semi-structured interviews, focus group discussions and participant observation field notes were analysed using reflexive thematic analysis as outlined by Braun and Clarke (2021). This approach was selected because it allows for systematic identification of patterns of meaning while remaining sensitive to context, lived experience and cultural interpretation, which are central to interpretivist phenomenological research.

The first stage involved verbatim transcription of all audio-recorded interviews and focus group discussions. Interviews conducted in isiZulu were initially transcribed in the original language to preserve culturally embedded expressions, metaphors and emotional nuances. These transcripts were subsequently translated into English for analytic purposes while maintaining semantic equivalence. Field notes from participant observation and reflexive journaling were typed and organised chronologically to support contextual interpretation.

The second stage involved familiarisation with the data. The researcher engaged in repeated reading of transcripts and field notes to develop an immersive understanding of participants' narratives. During this phase, preliminary analytic

memos were written to capture emerging impressions related to caregiving burden, cultural meanings of mental illness, coping strategies, gendered expectations and structural challenges. This iterative engagement enabled the identification of recurrent experiential patterns across participants.

The third stage involved initial coding. Codes were generated inductively from the data rather than imposed a priori, ensuring that participants' own language and meanings guided interpretation. Segments of text reflecting similar ideas or experiences were labelled with descriptive codes such as emotional exhaustion, spiritual interpretation of illness, medication challenges, community stigma, and family obligation. Coding was conducted manually to maintain close engagement with the narratives and to facilitate reflexive awareness of interpretive decisions.

The fourth stage involved searching for and constructing themes. Related codes were grouped together to form broader thematic categories that captured shared dimensions of caregiving experiences. For example, codes relating to financial strain, transport difficulties and food insecurity were clustered under structural and socio-economic challenges, while codes reflecting prayer, ritual practices and ancestral beliefs contributed to themes concerning cultural and spiritual coping. This stage required continuous comparison across participants' accounts to ensure that themes reflected patterned meaning rather than isolated experiences.

The fifth stage involved reviewing and refining themes. Emerging themes were examined in relation to the full dataset to ensure internal coherence and conceptual distinction. Some preliminary themes were merged, expanded or redefined as analysis progressed. Reflexive discussions with the research supervisor further supported analytic rigour by challenging assumptions and encouraging deeper interpretation of latent meanings within participants' narratives.

The final stage involved theoretical interpretation of themes. Identified themes were interpreted through the study's conceptual framework, including Social Constructionism, Feminist Theory and Social Identity Theory. This enabled movement beyond descriptive reporting towards analytical explanation of how caregiving experiences were shaped by socially constructed meanings of mental illness, gendered divisions of care work and identity negotiations within family and community contexts. The integration of theory at this stage strengthened the explanatory depth of the findings while maintaining fidelity to participants' lived realities.

Overall, thematic analysis in this study was conducted as a recursive and reflexive process involving continuous movement between data, codes, themes and theoretical interpretation. This systematic analytic approach enhanced the credibility, transparency and scholarly rigour of the research findings.

Engaging in this analytical process was intellectually stimulating and emotionally demanding. Revisiting transcripts often evoked the weight of caregivers' experiences. In one instance, a participant whispered in isiZulu, "inhliziyo yami iyagula" ("my heart is sick"), prompting me to pause the recording. The heaviness lingered long after analysis, reminding me that I was not only working with data but also with deeply lived pain. The process was challenging at times. My insider status as a Zulu-speaking woman from KwaZulu-Natal enabled me to instinctively understand cultural idioms and silences. However, this also risked over-familiarity. I had to remind myself not to take meaning for granted. For instance, when participants spoke of idliso (bewitchment through food), I initially assumed a shared cultural understanding. However, through reflexive journaling, I realised the importance of probing what idliso meant for each individual secondary sources' caregiver.

Practical challenges also arose. Translating isiZulu metaphors into English frequently proved inadequate. One participant shared, “ngiyapheka ngihlale ngedwa” (“I cook and sit alone”), which, on the surface, depicted a routine. However, I recognised its underlying symbolism of social exclusion and the solitude of caregiving. To preserve such meanings, I retained isiZulu phrases and provided contextual clarifications.

Reflexivity and Theoretical Integration

Throughout the analysis, I maintained a reflective journal to scrutinise my assumptions and prevent premature interpretive leaps. In one entry, I noted: “Reading these transcripts prompts me to consider my own mother’s role as a caregiver. While I empathise with their challenges, I must exercise caution to avoid conflating their narratives with my own recollections.” This reflexivity was crucial in maintaining a balance between empathy and analytical rigour. It also ensured consistency with the study’s interpretivist and phenomenological orientation, which posits that the researcher is not an impartial observer but an active participant in the construction of meaning.

Theoretical frameworks were reintroduced during the refinement of themes. Social Constructionism underscored how the meanings of illness are shaped through shared language and practices. Feminist Theory revealed how caregiving was socialised as women’s work but simultaneously rendered invisible in social and policy structures. Social Identity Theory illuminated how caregiving reshaped pride, stigma, and a sense of belonging. These frameworks were not imposed rigidly but employed as interpretive lenses, facilitating themes to transcend mere description and delve into structural and cultural explanations.

Thematic analysis provided a rigorous yet adaptable framework that transformed raw narratives into interpretive insights. It honoured the voices of participants, preserved cultural nuances, and contextualised home-based caregiving within

broader social contexts. My research experience was characterised by both emotional resonance and the challenge of balancing insider knowledge with analytical detachment. By triangulating across interviews, observation, and group discussions, this process yielded comprehensive, culturally grounded themes that captured the essence of home-based caregiving in Clermont as both personal labour and collective practice.

Reflexivity was an important component of the research process. As a researcher working within a South African township context, it was necessary to remain attentive to how my own social position, assumptions, and interactions with participants could influence the research process. Reflexive field notes were maintained throughout the study to document methodological decisions, emerging interpretations, and potential biases. This process enhanced transparency and strengthened the credibility of the research by encouraging continuous reflection on the relationship between the researcher, participants, and the knowledge produced.

3.9 Trustworthiness and Reflexivity.

This qualitative study's integrity was ensured by a dual commitment to trustworthiness and reflexivity. These were not procedural add-ons but interdependent practices that shaped the research process. Trustworthiness was addressed through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985; Nowell et al., 2022). While reflexivity ensured critical engagement with the researcher's positionality, making explicit how knowledge was co-constructed, these practices transformed methodological rigour from a checklist into a living process of accountability to participants, context, and scholarship.

Credibility

Credibility was established through sustained engagement and methodological triangulation. Over three months, I visited participants' homes, home-based caregiver groups, and prayer meetings, facilitating immersion in both the intimate and collective aspects of care. This consistency fostered the trust necessary for disclosures that transcended superficial accounts. For instance, during initial visits, some caregivers exhibited reserve, providing brief and cautious responses. However, as familiarity increased, they began to narrate more distressing and personal experiences, including instances of stigma and familial conflict. These gradual disclosures underscored that credibility is not attained immediately but is earned through presence, patience, and consistency.

Credibility was further reinforced by triangulating across interviews, observations, and group discussions, ensuring that identified patterns were not artefacts of a single method. As a researcher, I frequently valued this triangulation when revisiting data from diverse perspectives. For example, a theme that emerged in interviews regarding home-based caregivers' reliance on prayer was also evident in observations of daily routines and affirmed collectively in group discussions. Experiencing these patterns across methods instilled confidence in the findings' grounding in participants' realities rather than my own analytical assumptions.

As a researcher, I endeavoured to further consolidate the credibility of my findings. Initially, I shared preliminary interpretations with selected participants, who corroborated that the themes resonated with their lived experiences. One caregiver responded, "Indeed, that accurately captures my feelings; you have articulated what I endure." These moments were both affirming and humbling, serving as a reminder that participants were not passive informants but active co-constructors of meaning.

Simultaneously, I observed that some participants responded with polite nods without elaboration, prompting me to exercise caution in interpreting agreement where potential hesitation might have existed. This awareness guided my reflexive stance: credibility is inherently partial, contextual, and negotiated.

From my perspective as a researcher, credibility was intrinsically linked to reflexivity. My insider status, shared language, cultural background, and certain community experiences fostered trust, albeit at the risk of over-familiarity. To mitigate this, I meticulously documented analytic reflections after each engagement, scrutinising potential instances of shared understanding.

At times, my closeness to participants rendered their struggles personally relatable, causing me to carry their narratives with me long after I depart from the field. However, this emotional resonance also heightened my attentiveness, underscoring the fact that credibility extended beyond methodological rigour to encompass ethical responsibility to honour the depth of their testimonies.

Credibility was established through consistent presence, triangulation, member validation, and reflective practice. It was both a methodological and relational accomplishment, founded on the trust established with participants and the researcher's meticulous negotiation of insider knowledge, emotional engagement, and analytical detachment.

Transferability

Transferability was facilitated through the provision of comprehensive descriptions of Clermont's historical, socio-economic, and cultural contexts, enabling readers to gauge the extent to which the findings may apply to other settings. The study emphasised the interplay between apartheid legacies, persistent structural inequalities, and cultural pluralism in shaping home-based caregiving practices. This contextual richness ensures the findings aren't isolated

accounts but experiences in South African township life, making them conceptually transferable to other townships or resource-constrained contexts (Lincoln & Guba, 1985).

From my perspective as a researcher, ensuring transferability entailed going beyond mere reporting of caregivers' statements. It necessitated capturing the nuances of their lives in the crowded homes where interviews were conducted, the silences punctuated by the cries of relatives in distress, and the prayer circles where resilience was collectively reaffirmed. By including such detailed accounts, readers not only could hear caregivers' voices but also almost step into their environments, gaining a profound understanding of the material and emotional landscapes within which caregiving transpired.

I frequently reflected on how much of what I observed in Clermont mirrored dynamics I had observed in other South African communities where women predominantly bear the burden of caregiving, rely on kinship and faith structures, and face challenges against stigma. This reflexive awareness reinforced my belief that while the findings were deeply rooted in Clermont, they possessed "applicability" to broader township and under-resourced contexts, both within South Africa and globally. Simultaneously, I remained cautious about making universal claims. I noted in my reflective journal: "Clermont's narrative is not representative of every township's experiences. I must provide sufficient detail for readers to discern whether these findings resonate with their own contexts, rather than presuming it myself."

Transferability wasn't about statistical generalisation; it was about providing enough depth for readers and scholars to judge resonance. By presenting contextually rich, culturally grounded descriptions, the study allows others to determine how the insights might travel conceptually while honouring Clermont's unique caregiving landscapes.

Dependability

Dependability was ensured through transparency and auditability. Every stage of the research process, from recruitment to coding decisions and theme development, was meticulously documented in a methodological log. This log created a clear audit trail that could be followed by others. It not only included technical decisions but also reflexive notes, such as the reasons for merging certain codes, revisiting participants for follow-up interviews, and how contextual interruptions (e.g., home-based caregiving duties curtailing interviews) influenced the data's structure.

Debriefing sessions with supervisors provided an additional layer of scrutiny. These meetings facilitated the identification of potential blind spots in my interpretations and the refinement of thematic coherence. I recall presenting an early version of my coding framework, where I had consolidated multiple experiences of stigma into a single theme. My supervisor prompted me to consider whether I was oversimplifying distinct experiences rooted in church communities, health facilities, and kinship networks. This feedback prompted me to re-examine the data and retain thematic distinctions that more accurately represented participants' lived realities.

From my perspective as a researcher, ensuring dependability was not merely a procedural matter but an ongoing dialogue between consistency and flexibility. On the one hand, I sought to maintain a systematic process that could be traced; on the other, I had to remain responsive to the fluidity of participants' narratives. For instance, when a caregiver shifted mid-interview from discussing financial strain to recounting ancestral dreams, I initially felt uncertain about how to code it. I documented this dilemma in my reflexive journal, later realising that it reflected the pluralistic ways in which caregiving was understood. Rather than

imposing rigid categories, I permitted themes to remain layered, capturing the complexity of participants' accounts.

This iterative balancing act taught me that dependability is not about rigid uniformity but about methodological integrity, remaining consistent in process while responsive to meaning. By combining thorough documentation, supervisory dialogue, and reflexive practice, the study ensured that analytic decisions were both traceable and faithful to the richness of caregivers' lived realities.

Confirmability

Confirmability was achieved through triangulation and reflexive accountability. By drawing on multiple data sources, interviews, participant observation, and group discussions, findings were cross-checked to ensure that patterns were not the product of a single method or personal bias. For instance, the theme of prayer as resilience emerged not only in interview transcripts but was also observed in daily household routines and affirmed collectively in prayer circles. Seeing the same pattern across different methods reassured me that the interpretation was rooted in participants' lived realities rather than my own preconceptions.

A reflexive journal provided an additional safeguard by creating a written record of my emotional responses, assumptions, and analytic hesitations. In this journal, I documented moments when my insider knowledge risked slipping into taken-for-granted assumptions. For example, when a participant used the phrase “ukuphambana” (to lose one's mind), I initially understood it within the cultural framework I shared. However, in reflecting later, I realised that my interpretation might have overlooked her specific meaning in that context. This realisation prompted me to re-examine the transcript carefully and to probe more deeply in follow-up sessions.

The journal also captured the emotional weight of the analysis. After listening to a caregiver recount how neighbours accused her of neglect when her son relapsed, I wrote: “I feel a sharp anger rising in me. I recognise this emotion is mine, but I must ensure it does not overshadow her voice. My task is to represent her account faithfully, not to let my feelings of injustice dictate the analysis.”

Such reflexive writing helped me to slow down interpretation, separating participants’ voices from my own emotional reactions while still acknowledging that complete neutrality was impossible. From my perspective, confirmability was less about erasing subjectivity and more about making it visible and accountable. By acknowledging rather than denying my positionality, the study produced findings that were both transparent and defensible. The combination of triangulation and reflexive practice ensured that the analysis remained grounded in participants’ accounts, while also openly documenting the researcher’s interpretive role.

Reflexivity and Trustworthiness

Reflexivity was the central thread throughout this study. As a Black woman and insider, I navigated the paradox of proximity: insider status allowed me to enter intimate home-based caregiving spaces and build trust, but it also risked over-identification and the silencing of detail through assumed understanding. Participants sometimes said, “You already know what we go through,” reminding me that shared identity could both open and constrain disclosure.

To counteract this, I made a conscious effort to pose clarifying questions even when meanings appeared familiar, resisting the inclination to equate cultural resonance with analytical sufficiency. For instance, when participants referred to *idliso* (bewitchment), I refrained from assuming a shared meaning and instead inquired, “Could you elaborate on your understanding of this concept within your familial context?” These moments frequently unveiled nuances that I might have

otherwise overlooked. Reflexive journaling emerged as a pivotal instrument for managing moments of emotional resonance that threatened to diminish analytic distance. Following a particularly intense interview, I documented my thoughts as follows: “I felt compelled to provide comfort akin to a daughter or sister would, but I reminded myself that my role was to preserve her account as her own, not to incorporate it into my own narrative.” Documenting such responses facilitated my acknowledgement of my emotions without allowing them to succumb to analysis. Consequently, positionality was transformed from a potential source of bias into an epistemic resource.

Trustworthiness in this study was established through the integrated application of credibility, transferability, dependability, and confirmability, with reflexivity functioning as a central methodological principle linking these dimensions.

Credibility was maintained through extended immersion, methodological triangulation, and member validation. This was achieved by repeatedly visiting participants’ homes, prayer circles, and caregiver meetings over a three-month period, which facilitated the establishment of trust and the revisiting of accounts for depth. Subsequently, interpretations were shared with selected caregivers, who affirmed that the themes resonated with their lived experiences. This process reinforced the interpretivist position that participants were engaged as active contributors to meaning-making rather than as passive sources of information.

Transferability was facilitated by providing comprehensive descriptions of Clermont’s socio-economic and cultural contexts. This was achieved by positioning participants’ testimonies within detailed accounts of the township’s historical background, material conditions, and caregiving environments, thereby enabling readers to assess the applicability of the findings to other contexts.

Dependability was strengthened through the maintenance of a transparent audit trail. Each analytical decision was documented in a systematic log, encompassing coding challenges to thematic refinements. This process was further supported by

supervisory debriefings, which assisted in identifying potential bias in interpretation and encouraged sustained engagement with the complexity of participants' accounts.

Confirmability was ensured through triangulation and reflexive accountability. This was achieved by cross-checking findings across multiple data sources and maintaining a reflective journal that documented both assumptions and emotional responses. For instance, when my insider perspective risked presuming shared meaning, the journal facilitated a slower interpretation process and enhanced my engagement with the data.

Trustworthiness and reflexivity were embedded throughout the study as mutually reinforcing methodological practices. Reflexivity required that the researcher's perspective be made visible and critically interrogated throughout the research process, thereby supporting analysis that was both culturally sensitive and methodologically rigorous. By integrating these practices into the design and implementation of the research, methodological rigour was treated as a core component of knowledge production rather than as a procedural afterthought. This approach supported findings that remained grounded in participants' lived experiences while also generating conceptually informed insights relevant to broader debates in medical anthropology, caregiving studies, and feminist scholarship.

3.10 Ethical Considerations

Ethical practice served as the foundation of this study. Although formal approval was obtained from the University of KwaZulu-Natal Humanities and Social Sciences Research Ethics Committee (HSSREC), please see appendix C. My understanding of ethics extended beyond institutional compliance. As a researcher working within a community with which I shared linguistic, cultural, and social familiarity, ethics was approached as an ongoing process of negotiating

respect, trust, accountability, and care. Attention was directed not only to formal documentation and institutional procedures, but also to the relational dimensions of fieldwork, including modes of interaction, listening practices, and the preservation of participants' dignity.

Securing Ethical Clearance and Gatekeeper Permission

The process of obtaining approval was more challenging than I had anticipated. I meticulously prepared a comprehensive protocol, encompassing my interview guides, participant information sheets, and consent forms in both isiZulu and English. Submitting these documents to HSSREC necessitated careful consideration of potential risks that I had previously taken for granted, such as my response in the event of a distressed home-based caregiver or a participant disclosing information that posed a risk to themselves.

Once conditional approval was granted, I encountered the difficulty of securing a letter of recommendation from the local ward councillor. This process was not straightforward. Meetings were repeatedly postponed due to the councillor's political commitments, and when we finally met, there was confusion regarding his role. Initially, he suggested identifying participants for me, which I understood would compromise voluntariness and potentially create a sense of obligation among caregivers. This meeting highlighted an important reflexive tension between respecting local authority structures and safeguarding participant autonomy within the recruitment process. To resolve this conflict, I explained to the councillor that his role was to facilitate community access, not to determine who would participate in the study. Eventually, after presenting a draft letter and clarifying boundaries, he signed and stamped the gatekeeper letter. As recorded in the reflective journal, this process required the careful maintenance of ethical principles while negotiating access respectfully within a politically structured community setting.

Informed Consent as Relationship, Not a Form

Informed consent was approached not as a once-off procedural signature, but as an ongoing relational process that developed over time. I often sat with participants in their kitchens or living rooms, reading through the information sheets in isiZulu. Some participants requested that I explain certain terms again, while others admitted that they had difficulty reading. In such cases, I read aloud, paused for questions, and asked them to express their own understanding in their own words. One caregiver shared, “I believed that if I stopped you, you would become angry, but now I feel free because you allowed me to change my mind.” This interaction reinforced the view that consent extended beyond formal documentation and functioned as an ongoing process of reassurance, clarification, and voluntary participation. I revisited consent at every encounter, particularly during follow-up interviews. Each time, I reminded participants of their right to withdraw, even if they had already participated in the past. This iterative approach was methodologically necessary in a context where mistrust of outsiders and fear of mental health stigma shaped participation decisions.

Managing Emotional Distress and Counselling Referrals

Home-based caregiving narratives were frequently emotionally taxing. During one interview, a participant became visibly distressed while recounting gossip surrounding her son’s illness within the community. In response, recording was paused, the participant was given space, and the interview resumed only when she indicated readiness to continue. At times, participants expressed distress through silence or tears, requiring the researcher to respond with empathy while maintaining appropriate professional boundaries.

Concluding each interview and group discussion, I ensured participants were aware of accessible counselling services. I carried a printed sheet containing contact information for the local clinic social worker, the district hospital's psychiatric services, and helplines such as SADAG. Some participants discreetly tucked the information into their Bibles, while others admitted to being unfamiliar with these services. These practices underscored the ethical responsibility of the research to extend beyond data generation by ensuring that participants were informed of available support services where needed.

Confidentiality in a Township Setting

Protecting confidentiality in Clermont presented a complex methodological and ethical challenge. Within a close-knit community, information can circulate rapidly, while stigma associated with mental illness may heighten the risks attached to disclosure. Consequently, I often allow participants to select the most private settings for interviews, which may include bedrooms, kitchens, or shaded outdoor areas. Additionally, I assign pseudonyms and modify identifying information. However, it is important to note that confidentiality was more difficult to ensure during focus groups. Before commencing the session, I provided a clear explanation that while I would endeavour to safeguard their privacy, I could not control the potential dissemination of information outside the group. We collectively established ground rules for confidentiality. While some women expressed enthusiastic agreement, others exhibited hesitation. This discussion served to make participants aware of the limits of confidentiality in group-based settings and reinforced their autonomy in deciding what to disclose.

Reciprocity and Non-Coercion

As a researcher, I couldn't ignore the poverty and strain caregivers faced. Many asked if they'd be paid, but the study didn't offer remuneration. To ease their

burden, I provided refreshments and transport. I also promised to return with a summary of findings in isiZulu, so knowledge could flow back to them.

Reflexivity and Positionality in Ethical Practice

The researcher's positionality as an insider presented both methodological advantages and important reflexive challenges.

My identity as a Zulu-speaking Black woman facilitated rapport, cultural familiarity, and access within the field, while also creating the possibility that participants might presume shared understanding and leave important details unspoken.

Participants occasionally remarked that I was already familiar with their struggles. Although this fostered a degree of ease and shared identification, it also carried the methodological risk of reducing explicit articulation of lived experience. In response, I deliberately posed clarifying questions and avoided assuming equivalence between my own background knowledge and participants' specific meanings.

As documented in the reflective journal after one particularly intense interview, I became aware of the emotional pull of identification and the need to preserve analytic distinction between participants' experiences and my own personal responses. Reflexivity therefore functioned as a methodological safeguard by ensuring that positionality was neither denied nor allowed to operate uncritically, but instead used to support more careful, nuanced, and ethically attentive interpretation.

Ethical practice in this study was experiential rather than abstract. It encompassed negotiating access with political entities, assuring participants of their autonomy, managing emotional distress, safeguarding confidentiality within close-knit communities, and continuously reflecting on my own insider perspective. By integrating ethics into every encounter, from the initial meeting with the

counsellor to the final counselling referral at the conclusion of an interview, the study ensured that methodological rigour and moral responsibility were intrinsically linked.

3.10. Limitations of the Study

Like all qualitative research, this study presents limitations that must be acknowledged to ensure transparency and contextualise its contributions appropriately. These limitations do not diminish the significance of the findings but rather underscore the interpretive, situated, and partial nature of qualitative inquiry. They also suggest avenues for future research that could augment and broaden the insights presented herein.

Geographic Scope

The study was conducted exclusively in Clermont Township, KwaZulu-Natal, a semi-urban area with its own unique historical and socio-economic characteristics. While Clermont offers a valuable perspective for examining home-based caregiving in township settings, its conditions cannot be extrapolated to represent all South African caregiving experiences. For instance, home-based caregivers in rural areas may encounter even more significant obstacles to accessing psychiatric facilities, while those residing in metropolitan centres such as Johannesburg may face challenges associated with population density, mobility, and urban poverty. A participant herself acknowledged this, stating: “At least here in Clermont, there is a clinic nearby. In the rural areas, it is more challenging, as sometimes people have to walk for hours to find assistance.” (P8, Mother, 47 years)

To address this limitation, the study employed detailed descriptions of the context to facilitate transferability. Readers are thus provided with ample information to assess the applicability of the findings to other settings. Nevertheless, future

research would benefit from comparative, multi-site studies that explore both shared and divergent caregiving experiences across rural, peri-urban, and metropolitan settings.

Sample Composition

The study exclusively focused on twenty African female home-based caregivers, a deliberate choice reflecting the feminisation of home-based care in South Africa and a theoretical commitment to examining gendered labour. However, this design excluded the perspectives of male home-based caregivers, professional caregivers, and families from diverse racial or linguistic backgrounds. Several participants themselves acknowledged this limitation. One participant remarked, “Here, it is always us women. I have never seen a man sit at home with a sick child in the head. Perhaps their stories would be different if you asked them.” (P4, Cousin, 39 years)

Another participant added, “We are all women here, but maybe if you spoke to others, like Indian families or coloured families, they may explain things differently.” (P2, Sister, 33 years)

While this homogeneity facilitated depth and analytic focus, it restricted the potential for an intersectional analysis across gender, race, or class. Therefore, future research should incorporate more diverse participant groups to assess the validity of these findings and to uncover experiences currently concealed in female-only accounts.

Researcher Positionality

The researcher’s positionality, as a Black woman from the community, presented both advantages and challenges. My insider status fostered trust and openness, facilitating participants’ willingness to share deeply personal experiences. However, this closeness occasionally led to silences, as participants presumed

shared understanding and omitted certain details. One caregiver remarked, “You understand because I live like you. I don’t need to explain everything.” (Mother, 28)

I recognised the potential for over-identification and addressed it through reflexive strategies, including journaling and peer debriefing. Writing field notes about my emotional responses enabled me to discern between participants’ interpretations and my own assumptions. While these strategies mitigated bias, they could not eliminate it. Instead of viewing this as a deficiency, I embraced reflexivity as an integral aspect of interpretive rigour. Furthermore, I recommend that future research adopt collaborative approaches, such as co-analysis with participants or working with research assistants from diverse perspectives, to further broaden the scope of understanding.

Language and Translation

The majority of interviews were conducted in isiZulu and subsequently translated into English for analysis and presentation. While meticulous efforts were made to preserve the intended meaning, certain cultural idioms and emotional nuances proved challenging to translate directly. For instance, the phrase “ngikhathazekile enhliziyweni,” which literally translates to “troubled in the heart,” was rendered as “I am stressed,” which substantially diminished its inherent emotional impact. A home-based caregiver directly articulated this predicament: “Occasionally, when translating isiZulu to English, the resulting expression may appear less impactful. In isiZulu, the emotional intensity of the pain is more pronounced and nuanced, whereas in English, it may be perceived as merely stress. (P7, Ex-Wife, 48 years)

To address this, I retained selected isiZulu phrases in the analysis and provided interpretive glosses. However, I acknowledge that some linguistic nuance may have been inevitably lost. This limitation underscores the significance of

linguistic reflexivity and suggests that future research could employ collaborative translation workshops or bilingual co-authors to comprehensively safeguard cultural meaning.

Temporal Scope

Data were collected over three months, resulting in a comprehensive yet time-bound snapshot. This timeframe precluded the longitudinal observation of caregiving as it fluctuates through cycles of illness, relapse, and recovery. Participants themselves underscored the shifting nature of their experiences: “On certain days, I feel robust, as if I can manage. However, the following week, it feels as though I am drowning. If you were to visit me at a different time, I might share a different narrative.” (P3, Aunt, 47 years) “Today, I assert that I am coping, but tomorrow, circumstances may deteriorate. Life with this illness experiences fluctuations, and a single visit cannot comprehensively capture its entirety.” (P1, Mother, 58 years)

Although the limited timeframe facilitated intensive engagement, it was unable to capture the temporal dynamics of caregiving. Consequently, a longer ethnographic study or longitudinal design would complement these findings by tracing caregiving experiences over time.

Silences and Partial Disclosures

The sensitive nature of the subject matter resulted in unavoidable silences and partial disclosures. Topics such as family conflicts, domestic violence, or contested spiritual practices were occasionally only hinted at, either due to participants’ apprehension of gossip or the group format’s discouragement of disclosure. These silences hold analytical significance in themselves, reflecting the stigma associated with mental illness and the social risks inherent in open communication.

As a researcher, I opted not to press for disclosure in such instances, prioritising participants' dignity over the pursuit of completeness. This approach-imposed limitations on the data, but it aligned with an ethical commitment to providing care. Future research could explore more confidential formats, such as one-on-one follow-ups or diaries, or creative participatory methods, including storytelling workshops or visual techniques, to facilitate disclosure in safer and less direct ways.

3.11 Conclusion

This chapter outlines the study's methodological framework. It prioritised caregivers' lived experiences within Clermont Township's cultural and structural realities. Social Constructionism, Feminist Theory, and Social Identity Theory provided interpretive depth, while semi-structured interviews, participant observation, and group discussions offered complementary perspectives.

Thematic analysis was meticulously conducted, paying close attention to language and cultural nuances. Reflexive practice was employed to manage the researcher's insider position effectively. Trustworthiness was enhanced through strategies of credibility, transferability, dependability, and confirmability. Ethical practice was integrated as an ongoing relational process rooted in respect and care. Limitations, such as the geographic focus, sample composition, translation, and temporal scope, were acknowledged transparently as inherent characteristics of qualitative inquiry.

In conclusion, the chapter underscores that the methodological choices were coherent, ethically sound, and culturally sensitive, establishing a robust foundation for the findings presented in Chapter Four. The subsequent chapter delves into these findings, presenting them thematically and drawing upon the voices of caregivers to illustrate how home-based care is experienced, interpreted, and negotiated within the context of Clermont Township.

CHAPTER 4: UNDERSTANDING MENTAL ILLNESS

4.1 Introduction

This chapter presents the empirical findings relating to participants' understandings of mental illness. It focuses on the explanatory frameworks, meanings, and interpretations described by caregivers in relation to the conditions affecting their relatives. The chapter is organised thematically to show how participants understood mental illness through cultural, spiritual, biomedical, and social lenses.

4.2 Participants' Understandings of Mental Illness

Participants described mental illness using a range of explanatory frameworks. These included cultural interpretations, religious and spiritual explanations, biomedical understandings, and community-based stigma-related meanings. The following sections present these interpretations in relation to the narratives shared during the interviews.

4.2.1 Cultural Interpretations of Mental Illness

Many participants described mental illness using cultural explanations rooted in Zulu cosmology. They interpreted symptoms as signs of ancestral displeasure, witchcraft (*idliso*), or spiritual attack (*umeqo*). Instead of viewing illness as a random biomedical condition, caregivers framed it as socially and spiritually embedded, reflecting imbalances in relationships between the living, their ancestors, and the community. Within this worldview, behavioural disturbances such as hallucinations or erratic conduct were not meaningless disorders but meaningful signs that necessitated ritual or spiritual intervention. For caregivers, these cultural frameworks provided coherence in the face of distress, positioning suffering as communication or sanction that required action to restore moral and

spiritual order within the family. The following narratives illustrate how caregivers drew upon explanations of *amadlozi adinga into* (ancestral demands), *idliso* (witchcraft), and *umeqo* (spiritual entrapment) to comprehend mental illness in their households.

One home-based caregiver explained:

“Umndeni uthi lokhu kuphambana akukhona nje isifo. Kungenzeka amadlozi adinga into, ngoba uma ungazenzi izinto ezifanele, bayakukhumbuza.” (The family says this madness is not just an illness. It could be that the ancestors are demanding something, because when you do not fulfil what is required, they remind you.)

This narrative elucidates how mental illness is conceptualised not as a pathological condition of the brain but rather as a form of ancestral communication. The phrase “*amadlozi adinga into*” (the ancestors are demanding something) illustrates how symptoms can be interpreted as social sanctions, reminders of unperformed rituals, or neglected obligations. Within Zulu cosmology, ancestors are guardians of the family, expected to be honoured through practices such as *ukuphahla* (ritual offerings or prayers). When obligations are disregarded, misfortune, including illness, is understood as their way of restoring equilibrium. In this context, mental illness is perceived less as individual dysfunction and more as evidence of strained connections between the living and the ancestral realm.

For home-based caregivers, this framework transforms suffering into significance. Instead of random misfortune, illness becomes a directive: perform rituals, consult an *isangoma*, cleanse the homestead, or reconcile kinship disputes. Home-based caregiving thus extends beyond managing symptoms to restoring moral and spiritual order. This interpretation aligns with Kleinman’s (2020) argument that illness can function as a “symbolic reminder” of neglected

responsibilities. Simultaneously, the burden of fulfilling these obligations frequently falls on women, who must mobilise resources to finance ceremonies or sacrifices. Consequently, cultural interpretations both empower home-based caregivers with significance and burden them with responsibility.

P13, an aunt in her fifties, explained her nephew's condition as the result of witchcraft (idliso):

“Abanye bathi kwaba idliso, ngoba konke kwakuhamba kahle emsebenzini wakhe ngaphambi kokuba ahlanye.” (Some said it was witchcraft because everything was going well in his work before he lost his mind.)

In African cosmologies, illness is explicitly linked to jealousy and sabotage. Prosperity often invites envy, which may manifest as witchcraft intended to “pull down” those who attain excessive success. Within this perspective, mental illness is not an internal disorder but an external assault motivated by social rivalry. Consequently, home-based caregivers perceive illness as relational rather than confined to the patient's physical body but rooted in broader networks of jealousy and conflict. Protecting the patient entails safeguarding the family's social boundaries, consulting izinyanga (herbalists), or performing protective rituals.

This interpretation provides coherence to otherwise alarming symptoms while simultaneously generating community suspicion. Families affected by IDLISO may be avoided or subject to gossip, further isolating home-based caregivers. Therefore, idliso narratives simultaneously elucidate suffering and intensify stigma. They place home-based caregivers in dual roles: caring for the ill relative while simultaneously defending the family's reputation against accusations of spiritual vulnerability.

P5, a middle-aged caregiver, initially believed her relative's hallucinations indicated umeqo:

“Sathi ekuqaleni mhlawumbe ubethakathwe ngoba waqala ngokuziphatha ngendlela engajwayelekile, ebona izinto ezingekho.” (At first, we thought maybe she had been bewitched because she started behaving strangely, seeing things that were not there.)

For her, hallucinations were not random neurological occurrences but manifestations of a spiritual trap. The concept of *umeqo* describes snares set by malevolent entities, concealed within ordinary objects or spaces, that ensnare victims in confusion or visions. By interpreting symptoms as *umeqo*, the relative reframed unsettling behaviours into culturally comprehensible signs. Instead of perceiving these visions as meaningless psychosis, they were interpreted as the consequence of a spiritual assault that could be rectified through cleansing, herbal remedies, or protective rituals.

This rationale empowered families with actionable steps, yet it could also hinder psychiatric intervention. From a medical anthropological perspective, this illustrates how explanatory models structure care-seeking pathways: they direct families toward ritual specialists prior to (or concurrently) biomedical services. In this view, illness is not solely a medical condition but an ongoing struggle between human vulnerability and unseen forces.

Collectively, these narratives of *amadlozi* adinga into *idliso*, and *umeqo* demonstrate that cultural interpretations are not peripheral superstitions but fundamental frameworks through which home-based caregivers comprehend mental illness. Symptoms are reinterpreted as ancestral messages, manifestations of jealousy, or indications of spiritual entanglements. These models not only elucidate illness but also prescribe action, integrating caregiving within broader kinship and spiritual obligations.

For home-based caregivers, this dual role presents both a resource and a burden. Cultural interpretations provide coherence, mobilise social networks, and sustain

hope amidst uncertainty. Simultaneously, they intensify women's home-based caregiving labour, necessitating them to finance rituals, coordinate ceremonies, and mediate family and community conflicts. Consequently, illness transcends its biomedical classification; it becomes a socially and spiritually embedded phenomenon that engages home-based caregivers as mediators between the patient, the ancestors, and the community.

From a social constructionist viewpoint, this perspective underscores the agency of home-based caregivers as interpreters of illness, transforming disruptive behaviours into meaningful indicators. Simultaneously, it emphasises the gendered inequities inherent in cultural caregiving, where women disproportionately bear the burden of ritual, financial, and emotional labour. Consequently, cultural interpretations serve as both a protective resource and a source of strain, providing meaning while simultaneously exacerbating stigma, suspicion, and economic pressure in township settings such as Clermont.

4.2.2 Religious and Spiritual Explanations

While cultural interpretations rooted in ancestral belief systems provided initial frameworks for understanding mental illness, many caregivers simultaneously drew upon organised religious practices to further interpret and manage distress. The movement between cultural cosmologies and Christian faith traditions reflects the fluidity of township spirituality, where meaning-making is shaped by overlapping moral and theological influences. This thematic shift therefore illustrates how caregivers expanded their interpretive repertoires beyond ancestral logics to include divine testing, prayerful endurance, and congregational solidarity.

Religious frameworks offered an additional perspective through which home-based caregivers interpreted mental illness. For many, illness was not merely a biological disruption but a divine test, retribution, or spiritual challenge sent by

God. Within this framework, mental illness was understood as an integral aspect of a spiritual struggle, necessitating prayer, fasting, and church attendance to restore equilibrium. Spiritual leaders and congregations were regarded as pivotal allies, providing moral counsel, healing authority, and emotional support.

One participant explained:

“Samsa kumthandazi, kodwa futhi siya esibhedlela. Ngiyabona ukuthi imithi iyasiza kodwa nomkhuleko uyasiza. Ngakho-ke konke kudingeka.”
(We took him to a faith healer, but we also went to the hospital. I see that medicine helps, but prayer also helps. Therefore, everything is needed.)

In South Africa, mental illness is viewed as necessitating both divine and medical intervention. Caregivers do not solely interpret symptoms as a matter of brain chemistry but also as a spiritual burden that requires prayerful attention. This illustrates how faith-based interpretations broaden the interpretation of illness, positioning it as both a health concern and a measure of spiritual fortitude. By integrating prayer with medical treatment, caregivers made sense of suffering as a comprehensive experience where healing must encompass both the physical and spiritual realms.

P9, a 55-year-old mother, reflected on her daily reliance on prayer:

“Uma izinto ziba nzima kakhulu, ngiyavuka phakathi kobusuku ngithandaze. Ukukhuleka kwenza ngizizwe nginamandla futhi ngingaqulekiswa umthwalo osindayo.” (When things become too heavy, I wake up in the middle of the night to pray. Prayer makes me feel stronger and prevents me from collapsing under the weight.)

Her words convey an understanding of illness as a source of both spiritual and physical depletion. For her, prayer was not merely a source of solace but a recognition that illness carried moral and divine significance, presenting a

challenge that necessitated ongoing petition to God. The solitary act of praying at night underscores the interpretation of illness as a trial of endurance, where strength is directly drawn from divine presence.

This illustrates how religion provided not only a means of coping but also a rationale: home-based caregiving was perceived as participation in God's trial. From this viewpoint, symptoms such as insomnia and fatigue were not only medical manifestations but also spiritual burdens that could only be alleviated through prayer.

P5, a 38-year-old sister, connected church participation with renewed energy:

“Uma siya esontweni, sibuyela ekhaya sizizwe sinethemba futhi siphephile. Sengathi umthwalo uba lula ngoba abantu bayathandaza nathi.”

(When we go to church, we return home with hope and a sense of safety.

It feels as though the burden becomes lighter because people pray with us.)

Her narrative elucidates how illness was perceived as a spiritual threat to the family, necessitating collective prayer for the restoration of harmony. The church provided more than mere support; it interpreted mental illness as an integral component of a broader spiritual struggle, wherein communal prayer served as a protective shield.

This understanding underscore how home-based caregivers framed mental illness as not only a danger to the patient but also to the household's spiritual well-being. Congregational prayer was interpreted as a safeguard against despair, stigma, and even supernatural harm. Consequently, the church offered both theological explanations (“this is a test”) and practical rituals that reinforced the belief in the intrinsic connection between faith and healing.

P1, a 29-year-old daughter, emphasised the role of pastors:

“Umfundisi wethu uhlala esikhuthaza ukuthi lokhu akuyona into yokuhlazeka, kodwa ukuhlolwa kukaNkulunkulu. Lokho kuyangenza ngingazizwa ngedwa.” (Our pastor always reminds us that this is not something to be ashamed of, but a test from God. That makes me feel less alone.)

Her statement underscores how pastors directly influenced the comprehension of home-based caregivers regarding illness. Instead of perceiving it as a curse or indicative of familial failure, she came to view it as an integral component of God’s plan, a divine test. This reinterpretation of illness as spiritually significant not only validated her caregiving efforts but also protected her from the internalisation of societal stigma.

In this context, pastors serve as interpretive authorities: they translate mental illness into a theological narrative, providing home-based caregivers with a lens through which symptoms and suffering gain meaning. This religious interpretation mitigated social stigma by conferring dignity and elucidating illness as purposeful rather than shameful.

Finally, P3, a 46-year-old aunt, described how prayer became central to her caregiving routine:

“Ngimthandazela nsuku zonke ekhaya, ngoba ngiyabona ukuthi uma ngenza kanjalo uyaqina futhi nami ngiba nethemba.” (I pray for her every day at home, because I see that when I do so, she becomes calmer, and I also feel more hopeful.)

Her words illustrate how illness was perceived as necessitating spiritual healing within the confines of the home. Daily prayer transcended mere devotion, serving as an explanatory framework. It implied that the illness responded to divine

intervention and that both the patient and the home-based caregiver could be strengthened through faith.

This account demonstrates how spiritual interpretations transformed the home into a site of healing. Illness was understood as something that could be alleviated by the presence of God, mediated through prayer. For P3, observable changes in her relative's composure corroborated her belief that mental illness was, at the very least, of a spiritual nature and, consequently, necessitated ongoing divine attention.

Collectively, these narratives demonstrate that home-based caregivers in Clermont perceived mental illness not only as a medical condition but also as a spiritual trial, a divine challenge, and a moral obligation. Prayer, fasting, and church attendance transcended mere coping mechanisms; they served as explanatory frameworks that imbued otherwise perplexing symptoms with significance. Pastors and congregations functioned as interpretive communities, offering theological narratives that reframed suffering as purposeful and alleviated the stinging effect of stigma. These faith-based perspectives reinforced women's roles as spiritual guardians of their households, augmenting their burden while simultaneously conferring upon them moral authority.

4.2.3 Biomedical Understandings

In conjunction with cultural and spiritual perspectives, home-based caregivers also engaged with biomedical understandings of mental illness, which were introduced through clinics, hospitals, and medical consultations. Participants employed terms such as *isifo sengqondo* (illness of the mind), depression, schizophrenia, and bipolar disorder, reflecting their exposure to psychiatric categories. Biomedical interpretations reframed mental illness as a diagnosable

and treatable condition rooted in the brain and emotions, contrasting with but not supplanting cultural and spiritual explanations.

P20, a mother, explained:

“Ngiyamukela kokubili, ngoba ngiyabona ukuthi uma ethatha imishanguzo uyaphola. Kodwa kwesinye isikhathi kudingeka sibize umfundisi ekhaya.”
(I accept both, because I see that when he takes medication, he gets better. But sometimes it is necessary to call the pastor to the house.)

Her account reflects an understanding of illness as both a biological and a spiritual phenomenon. While acknowledging the efficacy of medication, she interpreted her relative’s condition through the lens of chemical imbalance and treatment response. Conversely, she emphasised the significance of pastoral intervention, underscoring the belief that illness cannot be fully comprehended or resolved solely through medical interventions. For her, biomedical frameworks provided evidence of progress, but they were insufficient without the spiritual support of prayer. This illustrates how caregivers perceived illness as multifaceted, encompassing both neurological and spiritual dimensions and therefore requiring a dual approach to management.

P14, a 34-year-old daughter, described how medical diagnoses helped her family interpret her mother’s struggles:

“Udokotela wathi unokucindezeleka okukhulu. Lokho kwangenza ngizizwe ngikhululekile ngoba ngangisola ukuthi mhlawumbe yidliso. Kodwa manje ngiyakwazi ukuthi imishanguzo iyasiza.” (The doctor said she has severe depression. That made me feel relieved because I suspected witchcraft. Now I know that the medication helps.)

Her narrative illustrates how biomedical naming transformed her family’s understanding of illness. The diagnosis of “depression” displaced their

interpretation from witchcraft towards a medical explanation. This transformation alleviated fear and uncertainty, legitimising symptoms as a mental illness rather than manifestations of supernatural assault. For P14, the doctor's words provided explanatory clarity, transforming perplexing behaviours into rational and treatable entities. However, her reference to earlier suspicions of idliso underscores that biomedical explanations did not supplant cultural ones but rather coexisted, presenting alternative avenues for comprehending illness.

Nolwazi, a 28-year-old sister, reflected on what she observed in her brother after he started treatment:

“Uma eqala imishanguzo, ngibonile ukuthi izinto ziyashintsha. Wayeseqala ukukhuluma futhi azole. Lokho kwangenza ngikholelwe ukuthi isifo sengqondo singelapheka.” (When he started medication, I saw changes. He began to talk again and became calm. That made me believe that mental illness can be treated.)

Visible improvement in her brother's condition strengthened her confidence in biomedical explanations of illness. She now saw mental illness as treatable, not a permanent curse. This changed her perception of her brother's future: symptoms were no longer signs of misfortune but indicators of a condition that could be treated. Biomedical frameworks explained illness and restored hope. Trust in medicine was built through tangible changes she observed in her brother's behaviour.

P12, a 50-year-old aunt, expressed her frustration with the fragility of health services:

“Ngesinye isikhathi asitholi imishanguzo ngesikhathi, noma abahlengikazi bayasixosha uma sibuze imibuzo. Lokho kuyasikhathaza ngoba siyafuna ukuqonda ukuthi kwenzakalani.” (Sometimes we do not get the medication

on time, or nurses chase us away when we ask questions. That worries us because we want to understand what is happening.)

Her experience highlights how biomedical understandings could be undermined by inconsistent access and inadequate communication. Despite her desire to comprehend her relative's condition through medical explanations, her attempts to engage with clinicians were disregarded. This eroded trust and compelled her to retreat to cultural or spiritual frameworks where her role as caregiver was acknowledged. Her narrative demonstrates that biomedical knowledge was not rejected due to its incomprehensibility, but rather because the system responsible for its dissemination was vulnerable and exclusionary.

Finally, Lindiwe, a 22-year-old caregiver for her older cousin, emphasised the importance of combining clinical advice with her own observations:

“Udokotela uthi kumele aqhubeke nemishanguzo, kodwa nami ngiyabona ukuthi uma engadli kahle noma engaphumeli ngaphandle izinto ziba zimbi. Ngakho imishanguzo kuphela ayanele, kudingeka nokunakekelwa ekhaya.” (The doctor says he must continue the medication, but I also see that when he doesn't eat well or go outside, things get worse. So medication alone is not enough; home care is also needed.)

Her reflection highlights the ways in which home-based caregivers extended biomedical categories through their own lived knowledge. While she acknowledged the medical explanation for symptom improvement, she also comprehended illness as associated with lifestyle and environmental factors. For her, mental illness was not reducible to chemical imbalance alone but necessitated daily practices of care, nutrition, exercise, and companionship in conjunction with medication. This demonstrates how caregivers acted as co-producers of biomedical knowledge, adapting clinical advice into holistic, lived frameworks.

Collectively, these narratives indicate that biomedical understandings provided caregivers with additional ways of interpreting mental illness. Diagnoses such as depression or schizophrenia validated perplexing behaviours, diminishing apprehensions of witchcraft and offering hope that conditions could be managed. Observable effects of medication reinforced these understandings, grounding them in lived experience. However, vulnerable healthcare systems, prolonged waiting periods, and dismissive encounters hindered trust and left biomedical explanations feeling incomplete. From a social constructionist perspective, home-based caregivers did not passively adopt medical models but actively negotiated them, integrating clinical categories with cultural and spiritual logics. In this manner, they constructed hybrid explanatory frameworks that reflected both formal expertise and household realities, demonstrating resilience, creativity, and agency in contexts of systemic neglect.

4.2.4 Medical Pluralism

Rather than adopting a single explanatory model, many home-based caregivers described integrating cultural, spiritual, and biomedical logics when interpreting and responding to mental illness. This hybrid approach underscores a pragmatic strategy of care, wherein families transitioned seamlessly between hospitals, churches, and traditional healers in pursuit of healing. Caregivers did not generally perceive these systems as mutually exclusive; instead, they regarded them as complementary, with each addressing different dimensions of illness. Mental illness was therefore understood not as a singular problem with a singular solution, but as a multifaceted condition requiring multiple forms of intervention. P17, a 47-year-old aunt, emphasised the importance of using both religious and biomedical care:

“Samsa kumthandazi, kodwa futhi siya esibhedlela. Ngiyabona ukuthi imithi iyasiza kodwa nomkhuleko uyasiza. Ngakho-ke konke kudingeka.”

(We took him to a faith healer, but we also went to the hospital. I see that medicine helps, but prayer also helps. Therefore, everything is needed.)

Her understanding of mental illness as both physical and spiritual underscores the importance of both medication and prayer in healing. For her, healing required a holistic approach, acknowledging the interplay between science and faith. This dual perspective reflects the home-based caregivers' belief that illness is a complex blend of chemical imbalances and divine trials.

P20, a 60-year-old mother, echoed this hybrid logic:

“Ngiyamukela kokubili, ngoba ngiyabona ukuthi uma ethatha imishanguzo uyaphola. Kodwa kwesinye isikhathi kudingeka sibize umfundisi ekhaya.”
(I accept both, because I see that when he takes medication, he gets better. But sometimes it is necessary to call the pastor to the house.)

Her narrative presents a biomedical perspective, acknowledging the efficacy of medication. However, it also underscores that the treatment was considered comprehensive only when pastoral involvement was integrated. For her, illness was not merely a malfunction of the brain but also a manifestation of spiritual discordance. Seeking the pastor's prayer in the home ensured that both the biological and spiritual aspects of illness were addressed. Consequently, pluralism transformed the very essence of illness, rendering it simultaneously medical, spiritual, and moral.

P2, a mother in her mid-fifties, described a similar negotiation:

“Siyamuthathela imishanguzo njalo, kodwa sikholelwa ukuthi kuyasiza nokuba nomkhuleko ekhaya. Uma kungenzeki konke lokhu, izinto azihambi kahle.” (We make sure he gets his medication, but we believe it also helps to have prayer at home. If both are not done, things do not go well.)

Her explanation highlights a “both/and” logic. For her, medication alone was insufficient; prayer was necessary to restore harmony within the household. This suggests that home-based caregivers viewed illness as relational, affecting not only the individual but also the household’s equilibrium. Consequently, healing entailed managing biological symptoms while simultaneously stabilising the social and spiritual environment through prayer.

P3, a 29-year-old home-based caregiver, described alternating between systems depending on circumstances:

“Uma sibona sengathi imithi yesibhedlela ayisebenzi, siya emthandazweni noma kumelaphi wesintu. Uma isimo sithuthuka, sibuyela kwimithi yasesibhedlela futhi.” (When we see that hospital medicine does not seem to work, we go for prayer or to a traditional healer. When things improve, we return to the hospital medicine again.)

Her account shows she understands illness as unpredictable and changing, needing constant evaluation. She sees mental illness as a condition that responds differently to interventions over time. Families move between systems because they believe illness demands flexibility, sometimes biomedical, sometimes spiritual or traditional.

P4, a 40-year-old sister, reflected on combining herbs with medication:

“Ngesinye isikhathi ngiyamenzela imbiza ekhaya. Ngiyabona ukuthi uma eqhubeka nemishanguzo yakhe, leyo mbiza iyamsiza ukuthi azole ngokushesha.” (Sometimes I prepare herbal medicine at home. I see that when he continues his tablets, the herbs help him calm down more quickly.)

For her, illness was understood as necessitating dual interventions: pharmaceuticals addressed the clinical aspects, while herbs targeted emotional

restlessness. This interpretation positioned traditional remedies not as alternatives but as augmentations of biomedical treatment. Consequently, illness was conceptualised as multifaceted, necessitating layered solutions that no single system could provide.

P7, a 22-year-old daughter, described her reliance on both churches and clinics:

“Ngiyazi ukuthi imishanguzo ibalulekile, kodwa uma ningamlethi esontweni, sengathi izinto azihambi kahle ekhaya. Umkhuleko usinikeza ukuthula.” (I know the medication is important, but if I don’t take her to church, it feels as though things do not go well at home. Prayer gives us peace.)

Her narrative illustrates that illness was perceived as impacting not only the patient’s physical well-being but also the emotional and spiritual health of the family. She recognised the significance of church attendance in preserving household harmony, alongside the medical management of symptoms. This demonstrates that pluralism encompasses not only the pursuit of cures but also the pursuit of holistic well-being for the patient, the family, and the household environment.

Collectively, these narratives reveal that medical pluralism was not indicative of indecision but rather a structured approach to comprehending illness. Home-based caregivers interpreted mental illness as multifaceted, simultaneously biomedical, spiritual, and social. Each system was perceived to address a distinct aspect of the problem: clinics for symptom management, pastors for spiritual fortitude, and traditional healers for protection or purification. From a social constructionist perspective, this pluralism underscores how meaning is collaboratively constructed through daily caregiving practices. It also highlights the role of women as knowledge brokers who evaluated efficacy, bridged between systems, and orchestrated multi-layered care strategies.

Simultaneously, pluralism reinforced the gendered nature of caregiving. Women assumed responsibility for coordinating clinic appointments, preparing herbal remedies, and maintaining prayer, thereby increasing their burdens while simultaneously affirming their authority as guardians of familial well-being. In this perspective, illness was not reduced to biological factors but was embedded within a holistic framework of meaning that necessitated ongoing negotiation between various systems.

4.3 Stigma and Social Understandings of Mental Illness

Home-based caregivers in Clermont Township emphasised the stigma associated with mental illness. Community members often labelled it as ukuphambana (“madness”), perpetuating exclusion and humiliation.

Sindi, caring for her brother, noted:

“Abantu bayakhuluma uma bebona umfowethu, bathi ‘uyahlanya.’ Igama nje lokuthi ‘uhlanya’ liyamhlaza.” (People talk when they see my brother, they say ‘he is mad.’ The word ‘mad’ is humiliating.)

For Sindi, the term “uhlanya” transcended mere description, serving as an identity marker that stripped her brother of dignity. Within the community, mental illness was understood through a language of shame, reducing intricate symptoms to a demeaning label. This exemplifies how stigma itself becomes an interpretive framework: instead of perceiving illness as treatable, neighbours interpreted it as an enduring state of madness. From a social identity theory perspective, Sindi’s account aligns with the concept of “courtesy stigma” (Goffman, 2023), wherein the family’s own standing is compromised by association.

P13, the youngest home-based caregiver, added:

“Umphakathi uyasijaji. Bacabanga ukuthi umndeni awuwunakekeli kahle, noma ukuthi lokhu kuhlanya kufakazela ukuthi ekhaya kukhona isiqalekiso.” (The community judges us. They think the family does not take proper care, or that this madness proves there is a curse in the household.)

In South Africa, mental illness was socially understood as a manifestation of either neglect or a curse. For instance, the diagnosis of her relative posed not only a family struggle but also a source of moral scrutiny. Neighbours interpreted the illness as evidence of failure or misfortune, subjecting the family to moral scrutiny. This exemplifies what Nxumalo (2023) refers to as the “moral economy of illness,” wherein misfortune is perceived as the consequence of unfulfilled social or spiritual obligations. This framing shifted the burden of responsibility onto caregivers, compelling them to defend both their relative and their family’s reputation.

P19, a 35-year-old sister, described how gossip shaped her social relationships:

“Uma ngikhuluma ngodadewethu, abantu bayangibuka sengathi nami ngiyahlanya. Ngaleso sikhathi nginquma ukuthula ngoba angifuni ukuhlazeka.” (When I speak about my sister, people look at me as if I am also mad. At that point, I choose silence because I do not want to be humiliated.)

Her words reveal how stigma affected her identity. In her community, discussing her sister’s illness risked implicating her as unstable. Illness was seen as a stain that spread across kinship lines. Her silence highlights stigma’s power to regulate speech and behaviour. It became a coping mechanism to preserve dignity, but it also deepened her isolation, reshaping her understanding of illness and the social world.

P18, a 44-year-old mother, shared the impact on her children:

“Ezinye izingane esikoleni zihlekisa ngendodakazi yami. Bathi ikhaya lethu lihlathwe isiqalekiso. Lokho kubuhlungu ngoba sekuthinta wonke umuntu emndenini wethu.” (Other children at school mock my daughter. They say our home is cursed. That is painful because it now affects the whole family.)

Her testimony elucidates the transgenerational nature of stigma. Illness was perceived by others as a manifestation of a curse, perpetuating humiliation for her children. This exemplifies how stigma operates as structural exclusion, not only isolating caregivers but also diminishing the social standing of their entire household, including younger generations. For P18, the burden extended beyond managing care, encompassing the emotional distress of witnessing her children bearing labels of “curse,” which negatively impacted their sense of belonging both within the school environment and within the community.

P7, a 26-year-old caregiver for her aunt, reflected on marriage prospects:

“Kunzima ngoba abantu bathi indlu enohlanya ayihlangani kahle neminye. Sengizwile abantu bethi amadoda ngeke asondele kimi ngoba ekhaya kunesifo.” (It is difficult because people say a house with madness cannot mix with others. I have heard people say that men will not approach me because there is illness at home.)

Her account illustrates the gendered consequences of stigma. Mental illness was perceived as a stain on the entire household, diminishing the marriageability of young women like P7. Within patriarchal community norms, her association with mental illness diminished her value in marriage negotiations, thereby reshaping her life opportunities. This demonstrates how stigma was not only exclusionary

but also gendered, reinforcing inequality by restricting women's social and relational prospects.

4.4 Comparative and Global Reflections

The findings of Clermont resonate with broader African and global contexts, where cultural and spiritual logics often coexist with biomedical care. In Uganda, Ethiopia, and India, families similarly draw upon pluralistic approaches that integrate prayer, rituals, and clinical medicine (Munie et al., 2024; Gupta, 2021). In contrast, studies conducted in Norway and the United States highlight the dominance of biomedical approaches, with limited recognition of spirituality in both diagnosis and treatment (Mendenhall, 2023). What distinguishes Clermont is not merely the presence of pluralism but its intensity and necessity under conditions of poverty, stigma, and inadequate healthcare systems. In these settings, medical pluralism serves not only as cultural continuity but also as a survival strategy that transforms caregivers' understanding of illness and their role within it.

P3, a 30-year-old caregiver, compared her family's practices with what she had heard about other countries:

“Ngizwa ukuthi kwamanye amazwe abantu baya odokotela kuphela. Kodwa thina lapha, asikwazi ukuthembela emishanguzweni kuphela. Kumele sihlanganise nemikhuleko, nemithi yendabuko, ngoba asazi ukuthi yini esebenza yongempela.” (I hear that in other countries people only go to doctors, but here, we cannot depend only on medication. We must combine prayer and traditional remedies, because we never know what will truly work.)

Her reflection underscores her awareness of global contrasts. For her, mental illness was not a condition with a single, stable cause or cure, but a shifting

problem that necessitated multiple logics. Medication addressed symptoms, but prayer and traditional remedies were equally essential to restore equilibrium. This pluralist interpretation aligns with what Silaule et al. (2024) describe as adaptive pluralism: a creative and resilient response to uncertainty. Home-based caregivers like P3 reframed systemic scarcity as an opportunity for innovation, mobilising all available resources to imbue suffering with meaning and secure hope.

P16, a 44-year-old aunt, emphasised the role of resource scarcity:

“Uma besithi e-United States imithi iyatholakala njalo, thina lapha kwesinye isikhathi siyahluleka ukuyithola. Lokho kwenza siphokeleke ukuthi siye kwesinye isikhungo, noma sibize umthandazi ekhaya.” (They say in the United States medication is always available, but here we sometimes fail to get it. That forces us to turn to another system, or call a faith healer at home.)

Her account discloses that pluralism was not merely a cultural preference but a structural compulsion. When biomedical systems failed due to medication shortages or dismissive staff, families turned to healers or churches, not out of confusion, but because survival necessitated it. This aligns with Janzen’s (2020) concept of therapy management, wherein households transition between systems based on availability and perceived efficacy. For P16, the very comprehension of illness was shaped by this fragility: it was perceived not as a condition with a singular treatment path but as a shifting struggle demanding continuous adaptation.

P15, a 46-year-old mother, linked pluralism to stigma:

“Uma abantu besikhomba ngomunwe bethi sinesiqalekiso, ngibona sengathi kumele ngizame konke imithi, umfundisi, nezangoma ukuze ngizibonakalise ukuthi ngiyazama ngempela.” (When people point fingers

and say we are cursed, I feel I must try everything, medicine, pastors, and traditional healers, to show that I am really trying.)

Her narrative reveals that pluralism was not only about treating symptoms but also about protecting moral standing. Illness was seen as a test of family responsibility, with failing to seek care leading to accusations of neglect or curses. For women like P15, ‘trying everything’ was therapeutic and performative, demonstrating diligence in the face of gossip. This aligns with feminist theory and social identity perspectives: women home-based caregivers, as the public face of family care, defended their household’s reputation. Pluralism became a moral performance as much as a healing practice.

In summation, these narratives demonstrate that while pluralism is prevalent in Africa and Asia (Munie et al., 2024; Gupta, 2021), in Clermont, it was exacerbated by two distinct factors: systemic scarcity and stigma. In contrast to high-income settings such as Norway and the United States, where biomedical reliability diminishes reliance on alternative therapies (Mendenhall, 2023), home-based caregivers in Clermont encountered underfunded clinics, irregular medication distribution, and entrenched gossip that compelled them to adopt diverse strategies. Consequently, illness was perceived as multifaceted and unstable, necessitating the transition between multiple logics to preserve hope and uphold dignity.

From a medical anthropology perspective, the pluralistic approach to illness in Clermont highlights the intertwining of cultural continuity and structural neglect. Home-based caregivers viewed illness as requiring attention to the body, spirit, and community reputation, rejecting compartmentalised health. This labour was gendered, with women coordinating clinic visits, seeking pastoral prayers, and consulting traditional healers, thus acting as knowledge brokers and guardians of family honour.

Pluralism, not confusion, is adaptive resilience. Health systems should acknowledge home-based caregivers' reliance on multiple logics and engage faith leaders and traditional healers in collaborative care. Anti-stigma interventions must address the moral pressure on women like P15 to exhaust options to prove their worth. Recognising pluralism as an explanatory and practice framework is crucial for designing services that align with caregivers' realities in township contexts.

4.5. Conclusion

The findings demonstrate that home-based caregivers in Clermont Township comprehend mental illness through overlapping systems of meaning that reflect both resilience and constraint. Cultural frameworks emphasised ancestors, witchcraft, and spiritual traps, providing coherence while simultaneously imposing ritual obligations on women. Religious interpretations reframed illness as a divine test, providing solace and legitimacy by naming conditions such as depression or schizophrenia. However, no single model was adequate; instead, caregivers combined multiple strategies that reflected pragmatic adaptation in contexts of poverty and inadequate healthcare. Stigma further influenced understandings, as illness was socially perceived as “madness,” a curse, or neglect, resulting in exclusion that extended across households and generations. Collectively, these perspectives highlight that mental illness in Clermont is not viewed as an isolated clinical diagnosis but as a socially and spiritually embedded condition that necessitates holistic responses. In aligning with the study's broader objectives, the chapter illustrates how home-based caregivers' interpretations illuminate the intricacies of mental health in township settings, underscoring the necessity of integrated approaches that acknowledge cultural logics, religious practices, and biomedical frameworks in conjunction with the lived realities of home-based caregiving.

Chapter 5: Home-Based Caregivers' Experiences of Mental Illness

5.1 Introduction

Home-based caregiving for relatives with mental illness in South Africa occurs within intricate socio-economic, cultural, and institutional settings that significantly influence the daily lives of home-based caregivers. In Clermont Township, KwaZulu-Natal, women are at the forefront of this caregiving role, simultaneously managing substantial household responsibilities while supporting relatives affected by psychiatric conditions. The objective of this chapter is to delve into the lived experiences of these home-based caregivers, elucidating how poverty, gendered expectations, social stigma, and interactions with the healthcare system shape their realities. By placing home-based caregivers' voices at the centre of the analysis, the chapter reveals that their struggles are both deeply personal and structurally influenced. The discussion is structured into four thematic areas: socio-economic and structural challenges, the gendered aspects of caregiving, stigma and social isolation, and relationships with healthcare professionals. Collectively, these themes address the study's objectives by demonstrating how home-based caregivers interpret and negotiate their roles, the burdens they bear, and how broader cultural and systemic forces impact their experiences of mental illness in their daily lives.

5.2 Socio-Economic and Structural Challenges

Building on the preceding discussion of caregivers' interpretive understandings of mental illness, the analysis now shifts from meaning-making to lived material realities. While cultural and spiritual frameworks shaped how caregivers conceptualised illness, their daily experiences were simultaneously structured by persistent socio-economic constraints that influenced how care was

practically enacted. Examining these structural conditions is therefore essential for understanding caregiving not only as a cultural practice but also as a survival strategy embedded within poverty, institutional fragility, and gendered expectations.

From a critical medical anthropological perspective, home-based caregiving in Clermont Township must be understood as structurally produced within conditions of poverty, gendered labour inequality, and fragmented mental health systems. These structural realities do not merely influence caregiving experiences but actively shape how caregivers negotiate moral responsibility, emotional endurance, and survival strategies in contexts marked by systemic neglect. Caregiving therefore emerges not only as a personal or familial obligation but as a socially embedded response to institutional gaps, where women's unpaid labour sustains both household stability and the functioning of overstretched public health services.

These barriers profoundly impact the daily lives of women who assume the responsibility of caring for relatives with mental health challenges. Their experiences demonstrate that caregiving transcends mere acts of love or obligation, encompassing a constant negotiation between survival and compassion. Limited financial resources, inconsistent access to medication, and unreliable healthcare systems compel caregivers to make difficult decisions regarding food, transportation, and medical attention. Within this context, resilience is continually tested as women navigate moral and emotional dilemmas under the weight of systemic neglect. From a medical anthropological perspective, these narratives elucidate how structural violence, gendered labour, and economic insecurity intertwine to perpetuate cycles of shared suffering within households. The subsequent accounts illuminate how caregiving in low-income township settings such as Clermont transforms into both an act of

perseverance and resistance against the broader inequities that define South Africa's social and healthcare landscape.

Home-based caregiving is a complex responsibility that affects various aspects of life. Participants in this study agreed that, beyond the financial burden, caregiving impairs their quality of life due to overwork and sleep deprivation. Consider P6, who shared what she calls her 'most pressing challenge'

“Uma engalali nami angilali. Ngesinye isikhathi ngizizwa ngikhathela kakhulu ngize ngicabange ukuthi mhlawumbe nami ngizogula.”

When she does not sleep, I do not sleep. Sometimes I feel so tired that I think maybe I will also get sick.)

P6's words reveal how illness affects the household, transforming sleep deprivation into a shared experience of suffering. Similar to P6, she shared that she sleeps for less than six hours every night. She further stated that she believes caregiving was designed for women because she feels men will never be able to carry the responsibility, as they are always busy with external (outside home) responsibilities and that she always feels unwell due to not having enough rest. Concurred by stating:

‘Society is funny. They say men do the hard work, but they don't see how much women do. I wake up at 6 to prepare for the family and keep the house clean so the patient can focus. Most jobs are for men, not women.

The provided excerpts illustrate the human capacity and the exhaustion associated with the role of caregivers. Favina et al. (2025) describe a shared suffering between patients and caregivers. The constant vigilance demanded of her erodes her resilience, pushing her to the brink of illness herself. In South Africa, Naidoo et al. (2025) found that women home-based caregivers frequently reported hypertension, chronic fatigue, and depression linked to sustained home-based

caregiving stress under conditions of poverty. From a resilience theory perspective, her statement underscores the fragility of adaptation: without structural support, coping mechanisms deteriorate, and resilience becomes unsustainable. This also highlights the impact of socioeconomic opportunities that are often said to favour men. This frequently leads to caregivers being financially vulnerable and having to make financial trade-offs.

“Uma imali iphela, ngincamela ngithenge ukudla kunokugibela i-taxi siye esibhedlela. Ngezinye izinsuku sithatha imithi sekudlule isikhathi ngoba sasingenayo imali yokuyolanda ngesikhathi.”

When money runs out, I would rather buy food than pay for a taxi to the hospital. On some days, we take the medication late because we didn't have the money to fetch it on time.

The narrative presented by P7 highlights the challenging economic dilemmas faced by home-based caregivers in Clermont. The decision to prioritise food over transportation underscores structural violence (Farmer, 2020), a systemic issue that restricts access to essential medical care for impoverished individuals. This choice is not indicative of neglect but rather a survival strategy aimed at ensuring the sustenance of the family while accepting potential delays in treatment. Silaule et al. (2024) observed similar patterns in township households, where the costs associated with transportation and food items consistently exceeded medical priorities, leading to medication adherence issues.

From a medical anthropological perspective, her decision underscores the moral negotiation that sustains the family's livelihood through food while simultaneously managing the risk of relapse. Comparative studies conducted in Uganda corroborate this notion: home-based caregivers strategically rationed biomedical care to maximise the utilisation of limited resources, often prioritising food over scheduled clinic visits (Munaru et al., 2025). The narrative of P7

underscores the way in which women who assume the role of home-based caregivers bear feminised responsibilities not only for their own health but also for the survival of their households, thereby illustrating the interplay between poverty and gendered labour. Policy interventions such as providing transport subsidies or implementing community-based medication delivery systems could potentially alleviate these seemingly insurmountable trade-offs.

P8 (53, sister):

“Uma sikhetha ukudla, siyayeka ezinye izinto. Kodwa imishanguzo uma iphelile, abahlengikazi baye bathi ‘buyani ngesonto elizayo bengenandabaukuthi kubenzima kanjani ukuthi sifike lanaa.” (When we choose food, we forget other things. But when the medication is finished, nurses sometimes say ‘come back next week,’ not knowing how difficult it is to get here.)

The testimony of P8 highlights the detrimental impact of poverty and inadequate healthcare systems on access to essential medical care. Despite families’ efforts to allocate limited resources towards prioritising clinical visits, medication shortages inevitably negate these sacrifices. The requirement for patients to return the following week not only wastes transportation costs but also exacerbates mistrust in the biomedical care system. Notably, the documentary “Spotlight” (2024) exposed widespread psychiatric drug stockouts in South Africa, resonating with P8’s concerns.

While women predominantly assume home-based caregiving responsibilities, the voice of P8 underscores how female home-based caregivers directly bear the brunt of systemic inefficiencies. In Ethiopia, Abate et al. (2024) identified similar concerns: home-based caregivers encountered medication shortages that compelled them to resort to improvisation, frequently relying on prayer or herbal remedies. This exemplifies how medical pluralism emerges as a response to

structural neglect. From Farmer's (2020) viewpoint, this is not mere random misfortune but evidence of health inequity resulting from systemic resource failures. P8's account emphasises the moral imperative to stabilise medication supply chains, acknowledging that each shortage exacerbates the sacrifices already made by families.

P11 (42, sister):

“Kunzima ukungasebenzi ngoba angiholi ndawo. Imali encane esiyitholayoiya ekudleni nasekuqasheni imoto yokuya esibhedlela. Angisenayo imali yokunye.” (It is difficult not being employed because I don't get paid. The little money we get goes to food and transport to the hospital. I have nothing left for anything else.)

P11's reflection underscores the severe economic burden of home-based caregiving compounded by unemployment. Her income is entirely consumed by sustenance and transportation, leaving insufficient funds for personal necessities and rest. This observation aligns with the political economy of care (Mbatha et al., 2024), wherein women contribute to public health systems through their unpaid and underpaid labour. From a feminist viewpoint, her testimony elucidates how structural inequality exploits women's dual roles as breadwinners and home-based caregivers, resulting in a double burden.

Similar findings in Uganda (Muwanguzi et al., 2025) and Ethiopia (Munie et al., 2024) indicate that women home-based caregivers frequently allocate all household resources towards survival needs and care, at the expense of their own well-being. P11's experience also demonstrates how resilience is constrained by structural limitations: while she continues to provide, she does so at the cost of her own financial and emotional health. Her words emphasise the pressing need for home-based caregiver grants or targeted income support, recognising home-based caregiving as a socially essential labour.

5.3 Gendered Dimensions of Caregiving

Beyond economic hardship, caregiving experiences were further shaped by deeply embedded gender norms that structured expectations of responsibility, endurance, and sacrifice within households. The transition from structural constraints to gendered labour highlights how poverty alone does not determine caregiving burdens; rather, socio-cultural ideologies about femininity and moral duty intensify women's caregiving roles. This thematic progression therefore enables a more nuanced understanding of caregiving as both materially constrained and socially regulated.

Caregiving within the context of mental illness in Clermont Township is analytically illuminated through Feminist Theory, which conceptualises women's disproportionate responsibility for emotional, domestic, and illness-related labour as structurally produced rather than naturally occurring. This perspective demonstrates how patriarchal social arrangements institutionalise women's caregiving roles, transforming care into a moralised expectation embedded within broader systems of gender inequality and socio-economic marginalisation.

These gendered expectations operate as mechanisms of social regulation that normalise women's disproportionate responsibility for caregiving labour while simultaneously obscuring the structural inequalities that produce such expectations. From a feminist political economy perspective, care is transformed into a moralised social duty that legitimises the extraction of women's emotional and physical labour without institutional recognition or material support. Consequently, caregiving becomes both an expression of cultural belonging and a site of structural exploitation, where women's resilience is socially celebrated yet materially unsupported.

Across households, caregiving is perceived as a woman's moral obligation rather than a shared familial duty. Sisters, mothers, aunts, and grandmothers become the

default caregivers, often without adequate support, recognition, or respite. This unequal distribution of labour mirrors what feminist scholars refer to as the feminisation of care work, where women's nurturing and emotional labour are taken for granted, invisibly supporting both the household and the healthcare system. The narratives that follow elucidate how cultural logics and societal expectations intertwine to define care as inherently feminine, reinforcing systemic inequities that exploit women's time, health, and emotions.

These accounts demonstrate how caregiving operates at the confluence of culture, morality, and gendered identity. Women are expected to embody patience, endurance, and sacrifice, while men are socially excused from domestic or emotional caregiving roles. This moralisation of female resilience transforms care from a voluntary act of love into a coercive social expectation. Within this framework, women internalise guilt, fear, and exhaustion as they strive to conform to community ideals of "good womanhood" and "good motherhood." The testimonies of caregivers in this section expose how patriarchy not only structures caregiving roles but also shapes the emotional and moral burden of care. Their voices reveal that the act of caring for a mentally ill relative is not merely a private family obligation; it reflects deeply ingrained gender hierarchies, where women's labour sustains both families and the gaps left by the healthcare system.

P2 (35, sister):

"Umndeni uhlala ubheka mina ngoba ngiyintombazane. Bathi kufanele ngibhekane nesigulo sikadadewethu ngoba amadoda anemisebenzi emikhulu. Noma ngikhathele, akekho omunye ozongisiza." (The family always looks to me because I am a woman. They say I must deal with my sister's illness because men have bigger responsibilities. Even when I am tired, no one else will help me.)

Similar to P2's account highlights how home-based caregiving is gendered by cultural and social expectations, positioning women as default home-based caregivers regardless of their personal capacity. Her statement reflects the normalisation of gendered division of labour, echoing Nkomo (2025), who argues that patriarchal systems frame care as "women's duty," reinforcing cycles of unpaid and undervalued labour. In the context of Clermont, this translates into the everyday assumption that sisters and daughters must take on care, even when it causes exhaustion. Her words also reflect the broader African pattern where home-based caregiving falls disproportionately on women, shaped by socialised notions of nurturing and endurance (Mbatha et al., 2024).

P2's experience highlights that home-based caregiving cannot be divorced from cultural logics of gender. Home-based care work is not merely a family decision but a socially enforced expectation associated with women's identity. Global studies corroborate similar dynamics: Gupta (2021) in India and Favina et al. (2025) in Uganda both demonstrate how daughters and sisters are positioned as primary home-based caregivers under the assumption that men's responsibilities lie outside the home. P2's exhaustion thus underscores not only the personal toll of home-based caregiving but also how patriarchy generates a structural imbalance where women bear both the practical and emotional burden of mental illness care while men are socially exempted.

P14 (50, grandmother):

"Ngiyakhathala kakhulu ngoba ngiphekela wonke umuntu ekhaya, ngihlanza indlu, bese ngibheka nomzukululu ogulayo. Umsebenzi awupheli, kodwa abantu bacabanga sengathi umsebenzi wesifazane akudingeki unconywe noma ubongwe." I get very tired because I cook for everyone in the home, clean, and also take care of my sick grandchild. The work never

ends, yet people think that a woman's work does not need to be recognised.)

P14's words highlight the invisible labour of women's domestic roles in home-based caregiving. Her description of endless cooking, cleaning, and care exemplifies the "triple burden" of domestic work, emotional labour, and illness care, as described by feminist theorists (Nkosi, 2022). The perception that women's work is unrecognised reflects structural invisibility, where unpaid female labour sustains families and health systems but is systematically devalued (Nkomo, 2025). In Clermont, this invisibility leads to older women like P14 being silently relied upon to manage intergenerational responsibilities without support.

Globally, this resonates with evidence from Nigeria, where elderly women were found to be the backbone of psychiatric care in households while still responsible for subsistence farming and childcare (Munie et al., 2024). In South Africa, Silaule et al. (2024) observed that grandmothers often bear the weight of home-based caregiving when adult children disengage, further entrenching feminised burdens. From a medical anthropology perspective, P14's exhaustion is not only personal but structural. Her body and energy are what Farmer (2020) would describe as "absorbing structural violence," as she fills the gap left by absent formal care systems. Her words remind us that unpaid female labour remains the invisible scaffolding of community survival.

P9 (40, mother):

"Ngiyesaba ukuthi uma ngingasakwazi ukubhekana nesifo sengqondo somntwana wami, abantu bazongibiza ngokuthi angiyena umzali oqotho. Umthwalo wengane ungowesifazane njalo." (I fear that if I cannot cope with my child's mental illness, people will call me an unfit mother. The burden of the child always falls on the woman.)

P9's reflection illuminates the gendered nature of home-based caregiving and its alignment with societal moral expectations of motherhood. Her apprehension about being labelled as an "unfit mother" exemplifies the concept of moral stigma, as proposed by Dlamini (2024). This stigma involves women being judged not only for the illness itself but also for their perceived success or failure in managing it. Consequently, women face double vulnerability: they shoulder the burden of home-based caregiving while simultaneously being held accountable for outcomes beyond their control. In Clermont, this manifests as mothers fearing societal judgment even as they grapple with structural resource deficiencies.

This moral framing transcends geographical boundaries. Khoza (2021) highlights that South African mothers of mentally ill children frequently encounter community criticism, accused of neglect or even being responsible for the illness's onset. Similarly, Mendenhall (2023) discovered that in the United States, mothers are stigmatised as inadequate when their children exhibit psychiatric symptoms. From a feminist perspective, P9's experience underscores how motherhood is socially exploited: women are judged based on their ability to "contain" mental illness, despite the fact that it is a chronic condition necessitating systemic support. Her words illustrate how home-based caregiving encompasses not only daily labour but also the safeguarding of social identity and maternal legitimacy.

P12 (47, aunt):

"Uma ngizama ukucela usizo, bahlale bethi 'abesifazane abanesineke, bazobhekana nakho.' Lokho kusho ukuthi akekho ozongiphatha njengomuntu okhathazekile." (When I try to ask for help, they always say, 'women have patience, they will handle it.' That means no one treats me as someone who is struggling.)

P12's account illustrates how patience, a feminine trait, is used to justify unequal home-based caregiving responsibilities. Communities offload care onto women, denying recognition of their struggles. This aligns with Nkomo (2025), who argues that "gendered resilience" is socially demanded rather than organically developed. P12's words reveal how resilience can become coercive, masking exploitation under the guise of feminine endurance. Studies across Africa support this observation. Lutasingwa et al. (2025) documented how Ugandan women were praised for patience and strength while denied support. Nkosi et al. (2024) found that South African home-based caregivers were celebrated as "resilient women" while left with inadequate resources. From a feminist anthropology lens, P12's account shows that gendered praise is a form of neglect that values women's endurance while absolving men, families, and health systems of responsibility. Her testimony highlights how gendered narratives are cultural discourse and lived oppression, trapping women in cycles of invisibility and unacknowledged suffering.

5.4 Stigma and Social Isolation

Home-based caregivers of persons with mental illness in Clermont Township face pervasive and painful challenges, including stigma and social isolation. Mental illness is often framed through moral and cultural lenses, attaching shame, blame, and fear to both the affected individual and their family. Caregivers, especially women, bear the double burden of managing illness while defending their family's dignity against gossip, ridicule, and exclusion. Stigma operates through language, social practices, and symbolic violence, reshaping relationships, identity, and belonging. It contaminates family reputation, limits marriage prospects, and erodes intergenerational well-being. Caregivers often resort to silence as a coping mechanism, protecting themselves from humiliation but deepening loneliness. Stigma in Clermont is not merely prejudice but a structural

force that reinforces marginalisation, disrupts social cohesion, and silences those who already carry the emotional weight of care.

P4 (36, sister):

“Abantu bayakhuluma uma bebona umfowethu, bathi ‘uyahlanya.’ Igama nje lokuthi ‘uhlanya’ liyamhlaza.” (People talk when they see my brother; they say ‘he is mad.’ The word ‘mad’ is humiliating.)

Similarly, P7 (56, aunt) described how neighbours whisper when her nephew walks past, saying.

“uyahlanya, uhlala ekhuluma yedwa” (“he is mad, he always talks to himself”).

She felt exposed and ashamed by such remarks, as if her household was marked by failure or disgrace.

Another caregiver, P9 (48, mother), shared a related experience:

“Abanye bathi uyasangana, ucosha maphepha, kodwa akunjalo uyazula ngoba udinga ukuphefumula” (“Some say he is going crazy, picking up papers, but that is not true, he walks around because he needs space to breathe”).

Her defence of her son shows the pain of being misunderstood, and the daily Caregivers face significant challenges in safeguarding the dignity of their loved ones.

P4’s statement illustrates how stigma manifests through language. The term “uhlanya” (“mad”) is not a neutral descriptor but a moral insult, positioning her brother outside the boundaries of respectability. This aligns with Goffman’s (2023) concept of spoiled identity, where a single label diminishes the complexity

of an individual and reduces them to a stigmatised condition. For P4, the humiliation extends beyond her personal experience, affecting her social standing as the insult tarnishes the family's reputation within the community. Recent South African research corroborates this dynamic: Dlamini (2024) discovered that derogatory terms such as “mad” or “possessed” persist, reinforcing exclusion in township settings.

Anthropologically, language transcends mere description; it is an active social practice that engenders exclusion. The label “uhlanya” transforms into a form of symbolic violence, delegitimising both the individual with mental illness and the home-based caregiver who advocates for them. Comparative evidence from Ethiopia and Uganda demonstrates similar effects, where home-based caregivers reported that insulting labels eroded their confidence in seeking support (Alamaw et al., 2024). P4's experience underscores how words function as instruments of stigma, shaping not only community perceptions but also the emotional landscapes of home-based caregivers, leaving them feeling humiliated and powerless.

P13 (28, daughter):

“Umphakathi uyasijaja. Bacabanga ukuthi umndeni awuwunakekeli kahle, noma ukuthi lokhu kuhlanya kufakazela ukuthi ekhaya kukhona isiqalekiso.” (The community judges us. They think the family does not take proper care, or that this madness proves there is a curse in the household.)

P13's account illuminates the moral economy of illness; wherein mental distress is interpreted as a manifestation of inadequate home-based caregiving or even a curse. This aligns with Nxumalo's (2023) observation that misfortune in African cosmologies is frequently perceived as a sign of social or moral imbalance. For P13, stigma extends beyond the individual to condemn the entire household,

jeopardising family honour and identity. This resonates with the concept of courtesy stigma (Goffman, 2023), wherein caregivers are discredited through association.

Internationally, this pattern is corroborated by research conducted in India and Uganda, where families caring for mentally ill relatives are frequently accused of neglect or witchcraft (Gupta, 2021; Ashaba et al., 2025). In South Africa, Khoza (2021) observes that home-based caregivers frequently internalise such judgments, experiencing guilt and shame even when they have limited control over the illness. P13's testimony demonstrates how stigma operates as structural exclusion: it not only isolates families socially but also dissuades them from seeking external support due to the apprehension of reinforcing negative stereotypes.

P19 (35, sister):

“Uma ngikhuluma ngodadewethu, abantu bayangibuka sengathi nami ngiyahlanya. Ngaleso sikhathi nginquma ukuthula ngoba angifuni ukuhlazeka.” (When I speak about my sister, people look at me as if I am also mad. At that point, I choose silence because I do not want to be humiliated.)

P19's words exemplify the phenomenon of identity contamination, where the stigma associated with the ill relative extends to the primary caregiver. Her silence serves as both a coping mechanism and a form of self-protection against humiliation. From a social identity theory perspective, she grapples with a fragmented identity, both as a sister and as an involuntary categorisation as “tainted.” This aligns with Dlamini's (2024) observation that home-based caregivers frequently withdraw from social interactions to avoid being associated with mental illness stigma.

From a resilience standpoint, P19's silence may be perceived as adaptive in the short term, safeguarding her dignity. However, it could be considered maladaptive in the long term, as it isolates her from potential social support. Similar coping strategies have been documented in Ethiopia, where caregivers-maintained silence to avoid gossip but subsequently expressed profound feelings of isolation (Tilahun et al., 2024). Her experience underscores how stigma not only marginalises patients but also actively reshapes caregivers' social participation, resulting in their silencing and exacerbating loneliness.

P18 (44, mother):

“Ezinye izingane esikoleni zihlekisa ngendodakazi yami. Bathi ikhaya lethu lihlatshwe isiqalekiso. Lokho kubuhlungu ngoba sekuthinta wonke umuntu emndenini wethu.” (Other children at school mock my daughter. They say our home is cursed. That is painful because it now affects the whole family.)

The account of P18 illustrates how stigma perpetuates itself across generations, impacting not only primary caregivers but also their children. When her daughter is subjected to bullying at school, the entire family identity is tarnished, reinforcing exclusion across generations. This aligns with Dlamini's (2024) definition of stigma as social violence, where discrimination in educational institutions and communities perpetuates cycles of marginalisation. For P18, the emotional distress is compounded by the fact that stigma now jeopardises her child's future, not only her own role as primary caregiver.

Internationally, similar findings have been reported. In Uganda, children of mentally ill parents reported being bullied and socially excluded (Hobe et al., 2025), while in South Africa, Adams et al. (2024) identified generational stigma that limited educational opportunities for families. From a feminist perspective, P18's narrative underscores the burden women bear as protectors of family

honour, bearing stigma not only on their own behalf but also on behalf of their children. This demonstrates how stigma functions as a structural force that perpetuates inequality over time.

P7 (26, niece):

“Kunzima ngoba abantu bathi indlu enohlanya ayihlangani kahle neminye. Sengizwile abantu bethi amadoda ngeke asondele kimi ngoba ekhaya kunesifo.” (It is difficult because people say a house with madness cannot mix with others. I have heard people say that men will not approach me because there is illness at home.)

P7's experience shows how stigma affects women's marriageability and belonging, especially in patriarchal societies where women's worth is often linked to marriage, and mental illness can lower that value. Her testimony concurs with feminist critiques of home-based caregiving, which demonstrate that women not only bear the burden of caregiving but also the stigma that impedes their life opportunities (Nkomo, 2025). For P7, stigma is not abstract but tangible: it diminishes her prospects for forming relationships and fulfilling anticipated life roles.

Research conducted in Ethiopia (Tiruye et al., 2024) and South Africa (Khoza, 2021) corroborates this finding, indicating that young women from households with mentally ill relatives frequently encounter diminished marriage prospects due to perceptions of “tainted” bloodlines or cursed families. P7's testimony from a medical anthropology perspective underscores how stigma in kinship systems influences present home-based caregiving and future generations' opportunities. It emphasises that stigma not only excludes women socially but also limits women's life trajectories.

5.5 Relationships with Health Practitioners

The relationship between home-based caregivers and health practitioners in Clermont Township exhibits a multifaceted interplay of power, respect, and cultural misunderstandings that significantly impacts the quality of mental health care. For numerous caregivers, encounters with healthcare professionals are characterised by frustration, humiliation, and exclusion, resulting in dismissal, disregard, or prolonged waiting periods. These negative experiences mirror broader patterns of structural stigma and institutional neglect that isolate caregivers from the very systems intended to support them. However, amidst these challenges, instances of empathy and clear communication, such as when medical professionals take the time to elucidate treatment plans, provide glimpses of healing and empowerment. From a medical anthropology and feminist perspective, the caregiver-health practitioner relationship transcends medical transactions to encompass concerns about dignity, recognition, and collaboration. It also highlights tensions between biomedical authority and indigenous healing practices, where caregivers often conceal their utilisation of traditional medicine due to apprehension of ridicule. The narratives that follow underscore the significance of trust, respect, and cultural sensitivity in bridging this divide, ensuring that home-based caregivers are not passive recipients of instruction but active, valued collaborators in preserving the mental well-being of their loved ones.

P5 (38, mother):

“Uma ngifika esibhedlela ngicela usizo, kwesinye isikhathi bayangixosha noma bathi ngilinde isikhathi eside. Ngizizwa bengangiboni njengomuntu obalulekile.” (When I arrive at the hospital and ask for help, sometimes they chase me away or tell me to wait a long time. I feel as though they do not see me as an important person.) x3

P5's account illustrates how systemic neglect within healthcare settings perpetuates the invisibility of home-based caregivers. Being "chased away" or subjected to prolonged waiting periods conveys to her that her contributions as a partner in care are disregarded. This aligns with Dlamini's (2024) concept of structural stigma, wherein institutions prioritise the needs of mentally ill patients' families, thereby reinforcing marginalisation. P5's words underscore how home-based caregiver engagement with biomedical care is undermined not by a lack of will but by the disrespect and inefficiency inherent in the system. Similar findings in Botswana indicate that when nurses dismiss caregivers, families refrain from returning to clinics, opting instead for traditional healers (Sakwape et al., 2025).

P5's experience exemplifies how power imbalances shape clinical interactions. Kleinman (2020) posits that home-based caregivers' accounts of illness are influenced as much by encounters with professionals as by their symptoms. In this case, biomedical authority positions P5 as subordinate, invalidating her knowledge and labour. Globally, Manaru et al. (2025) report analogous dynamics in Uganda, where caregivers felt excluded and unrecognised by healthcare staff, compromising the continuity of care. P5's account highlights the urgent need for culturally sensitive, caregiver-inclusive psychiatric care in South Africa, where trust is built on dignity and recognition.

P12 (47, aunt):

"Kwesinye isikhathi kukhona udokotela ongithokozisayo ngoba uyachaza ukuthi imishanguzo isebenza kanjani. Lokho kwenza ngizizwe nginesibindi sokubuya futhi." (Sometimes there is a doctor who makes me happy because he explains how the medication works. That gives me the courage to return.)

Respectful communication transforms the experience of home-based caregivers. When doctors explain medication, caregivers feel valued and engaged partners in

treatment, leading to improved adherence and reduced fear. Naidoo et al. (2025) discovered that home-based caregiver education substantially enhanced treatment adherence and decreased relapse rates among South African psychiatric patients. For P12, the encouragement she receives not only imparts knowledge but also instils emotional resilience, enabling her to persist in returning to clinics despite structural obstacles.

Her words also reflect the role of supportive external relationships in sustaining home-based caregivers under strain. A feminist perspective further reveals that the recognition of women's unpaid caregiving is itself empowering: it validates invisible labour that is often dismissed as "natural." Comparative research reinforces this: Taye et al. (2024) in Ethiopia observed that home-based caregivers valued biomedical care more when practitioners explained treatment plans clearly, while Mendenhall (2023) found that in Norway, trust in doctors reduced stress for family home-based caregivers. P12's testimony demonstrates that small acts of respect, such as explanation and reassurance, can dramatically shift home-based caregiver-health practitioner relationships from alienating to supportive.

P9 (40, mother):

"Angikwazi ukukhuluma ngamuthi esintu nodokotela ngoba besaba ukuthi bazongihleka. Ngizothula ngiyenze ngasese ekhaya." (I cannot talk about traditional medicine with doctors because I am afraid they will laugh at me. I keep quiet and do it secretly at home.)

P9's account illustrates how home-based caregivers manage medical pluralism by concealing their use of traditional remedies. Her apprehension of ridicule reflects a clash of explanatory models (Kleinman, 2020), wherein biomedical authority undermines indigenous healing practices. By silencing her practices, P9 safeguards herself from humiliation but also risks unsafe combinations of

biomedical and traditional treatments. South African research corroborates this pattern: home-based caregivers frequently refrain from discussing herbal or spiritual remedies at clinics due to fear of judgment (Khoza, 2021). This silence hinders open dialogue and can result in adverse drug interactions.

From a structural violence perspective (Farmer, 2020), the concealment of P9's pregnancy by the family is not merely a personal decision but a survival strategy within a healthcare system that exhibits a lack of cultural pluralism. Globally, Gupta (2021) in India and Rubega et al. (2025) in Uganda have observed that families frequently harmonise biomedical and spiritual practices, yet they choose to conceal this from medical professionals. Culturally sensitive care that recognises legitimate healing pathways is crucial. Without this, home-based caregivers like P9 are forced into secrecy, damaging trust and limiting safe, holistic care.

P3 (50, grandmother):

“Ngesinye isikhathi uma ngifika emtholampilo ngithwele kanzima, udokotela uyangibuka athi, ‘lena indaba yokuhlanya, akukho engikwenzayo.’ Ngibuyela ekhaya ngidangele.” (Sometimes when I arrive at the clinic struggling, the doctor looks at me and says, ‘This is a madness issue, there is nothing I can do.’ I return home discouraged.)

P3's narrative illuminates the devastating impact of biomedical nihilism. When caregivers are informed that there is nothing they can do, it can strip them of hope and frame mental illness as untreatable, discouraging them from continuing their care. Mendenhall (2023) refers to this as therapeutic nihilism, a discourse that undermines confidence in psychiatry by portraying mental illness as beyond help. For P3, the consequence was discouragement and withdrawal, echoing findings from Southern Africa where negative clinic encounters led families to abandon formal care (Adams et al., 2024). Her account also underscores the gendered

burden of discouragement. Women home-based caregivers must not only bear the suffering of their relatives but also the emotional weight of institutional dismissal. Globally, there are parallels: Abate et al. (2024) report that Ethiopian home-based caregivers abandoned clinics after being informed that treatment was ineffective, while Lutasingwa et al. (2025) found Ugandan families described hopeless biomedical narratives as profoundly disempowering. P3's account emphasises the pressing need for psychosocial training of healthcare workers to prevent hopeless messaging and instead promote collaborative, hopeful approaches that maintain the trust of home-based caregivers.

5.6. Conclusion

This chapter delves into the lived experiences of home-based caregivers of relatives with mental illness in Clermont Township, underscoring how their roles are influenced by socio-economic challenges, gendered expectations, stigma, and interactions with healthcare professionals. Home-based caregivers recounted making distressing trade-offs between sustenance and transportation, enduring medication shortages, and bearing the invisible burden of household and home-based caregiving responsibilities traditionally associated with women. Stigma manifested as a formidable force, not only labelling relatives as “mentally ill” but also tarnishing home-based caregivers' identities, isolating families, and even restricting children's educational opportunities and young women's marriage prospects. Encounters with the healthcare system revealed both supportive and alienating experiences: while clear explanations and empathy fostered trust, prolonged waits, dismissive attitudes, and ridicule discouraged engagement, compelling some caregivers to maintain secrecy or withdraw. Collectively, these findings demonstrate that caregiving transcends the realm of domestic tasks,

becoming a socially embedded, structurally constrained, and profoundly gendered experience in which caregivers exhibit both resilience and vulnerability.

Chapter 6: Home-Based Caregivers' Coping Mechanisms for Mental Illness

6.1 introduction

Home-based caregiving for relatives with mental illness in Clermont Township presents challenging conditions characterised by poverty, stigma, gender inequality, and limited institutional support. These factors compel home-based caregivers to continuously seek coping strategies to manage emotional, physical, and practical burdens. This chapter analyses the coping mechanisms employed by home-based caregivers to manage stress, sustain care, and preserve dignity amidst overwhelming challenges. By presenting participants' perspectives alongside analysis, the chapter underscores that coping is not merely an individual trait but a socially embedded and culturally informed practice.

The chapter presents four thematic frameworks: adaptive coping strategies such as prayer, routines, peer support, and acceptance; maladaptive strategies including withdrawal, frustration, and overmedication; the role of networks and support systems in mitigating strain; and cultural and gendered influences that shape the decisions made by home-based caregivers. These findings align directly with the study's objectives by demonstrating how caregivers navigate survival in the face of mental illness, illustrating both their resilience and the vulnerability of their coping strategies in under-resourced township settings.

6.2 Adaptive Coping Strategies

Having established the structural and emotional burdens associated with caregiving, the analysis now turns to the everyday strategies caregivers employ to sustain themselves and their households. Coping practices did not arise in isolation but were deeply shaped by cultural belief systems, social relationships, and the constant negotiation of uncertainty. Understanding adaptive coping

therefore provides insight into how caregivers actively reconstruct resilience within environments marked by instability and limited institutional support.

For numerous home-based caregivers in Clermont Township, faith and spirituality emerged as pivotal sources of strength, solace, and meaning amidst overwhelming emotional and physical demands. In the absence of formal psychosocial support, prayer, church fellowship, and ancestral connection provided caregivers with emotional release and a renewed sense of purpose. Faith served as a stabilising force, enabling caregivers to reinterpret their struggles as integral to a divine plan or sacred duty rather than personal failures. Through prayer, worship, and spiritual rituals, caregivers found solace, moral affirmation, and a sense of companionship in otherwise isolating circumstances. This section delves into how caregivers utilise faith as a form of emotional resilience and meaning-making, proving how spiritual belief functions not only as a coping mechanism but also as a deeply ingrained cultural and therapeutic practice within township life.

Faith and spiritual reliance are crucial for coping with the challenges of caregiving for people with mental illness, as P18 shared.

“Uma izinto ziba nzima kakhulu ngihlala ngithandaza. Ngizwa sengathi ngingedwa kodwa uNkulunkulu uyangibona futhi ungipha amandla okuqhubeka.”

(When things get very difficult, I keep praying. I may feel alone, but God and only God sees me and gives me the strength to carry on.

Participant 5, like P18, believes prayer is her source of strength. She prays when she's exhausted, like reaching out to her wise friend. P1, on the other hand, feels relieved only after praying to her ancestors.

P18's story shows how prayer sustains her during isolation and exhaustion. For her, spirituality transforms emotional burdens into resilience, reinforcing her belief in her connection to the world. This aligns with resilience theory, which posits that meaning-making through faith serves as a protective factor against prolonged stress (Favina et al., 2025). Her reliance on prayer also mirrors how women often reinterpret unpaid care work as sacred labour, a concept echoed in Khoza's (2021) South African study, which revealed that home-based caregivers perceived their labour as a divine calling. By positioning home-based caregiving within a moral and spiritual framework, prayer alleviates feelings of invisibility and fosters a sense of partnership with God in sustaining care.

On a broader scale, P18's testimony underscores how faith mitigates the absence of formal psychosocial support in under-resourced communities. Where healthcare systems fail to provide counselling or respite care, prayer assumes the role of "self-therapy," restoring hope and dignity. Studies conducted in Uganda and Botswana corroborate that home-based caregivers heavily relied on spiritual practices when institutional support was constrained (Sakwape et al., 2025). From a medical anthropology perspective, prayer illustrates the integration of religious logics into daily coping mechanisms, demonstrating how home-based caregivers convert spiritual resources into survival strategies. P18's words thus reflect resilience that is both vulnerable and potent: vulnerable because it relies on belief rather than structural transformation, yet potent because it enables perseverance against insurmountable challenges.

P2 (35, sister):

"Isono liyindawo engikhulula khona yonke imithwalo engisindayo. Lapho ngizizwa nginamandla futhi ngiyakwazi ukubhekana nezinsalelo zami ekhaya." (Church is where I find relief. There, I feel stronger and able to face the challenges at home.)

Like P2, P1 finds solace in spiritual and holy places, like waterfalls, to overcome her challenges. She visits the waterfall regularly, sometimes with church members, and sometimes alone. She believes the waterfall serves a similar purpose to the church for born-again Christians, as it's where she connects with her ancestors.

The narrative of P2 illustrates how communal worship provides emotional solace and empowerment. In contrast to solitary prayer, which sustains the individual, the church offered her solidarity and a sense of belonging, thereby validating her struggles through collective recognition. This aligns with the Ubuntu philosophy, which emphasises the interconnectedness of individuals and reinforces resilience by affirming shared humanity (Naidoo et al., 2025). By portraying the church as a source of relief, P2 demonstrates how religious communities serve as informal psychosocial spaces, providing a substitute for absent formal services. In Ethiopia, similar findings indicated that caregivers perceived church groups as places where burdens could be shared without social stigma (Taye et al., 2024).

From a feminist viewpoint, P2's experience shows how women find strength in collective networks that recognise and validate their invisible care work. Her reliance on church solidarity emphasises that home-based caregiving is not just an individual responsibility but a social experience shaped by gender and culture. Comparative evidence from Norway indicates that when home-based caregivers have access to formalised peer groups, their emotional well-being significantly improves (Mendenhall, 2023). In contrast, in Clermont, where such services are limited, church spaces serve as a substitute for structured therapy. P2's words thus reflect the dual role of faith spaces: they serve as both spiritual anchors and community-based resources for resilience, affirming that home-based caregiving is a collective struggle sustained by shared belief.

6.2.1 Routines and Structure in Home-Based Caregiving

Within the intricate realities of home-based caregiving in Clermont Township, routines and structure emerged as potent instruments of stability and survival. Caregivers repeatedly described how establishing daily schedules for meals, medication, rest, and household responsibilities facilitated the restoration of a sense of control in environments characterised by unpredictability and emotional distress. Routines were not only practical mechanisms for managing the needs of individuals with mental illness but also symbolic acts of order, dignity, and resistance against chaos. Through structured daily practices, caregivers endeavoured to anchor both themselves and their households, transforming repetition into a coping strategy that preserved emotional equilibrium and diminished anxiety. This section delves into how caregivers' reliance on routines and household regulations became integral to their caregiving identity and resilience, illuminating the interplay between structure, mental well-being, and social dynamics within their homes.

P7 (young mother):

“Ngiyazama ukuthi kube nesikhathi esibekiwe sokudla, sokulala, nangokuthatha imithi. Uma kungekho i-routine izinto azihambi kahle.” (I try to make sure there are set times for meals, sleeping, and taking medication. Without routine, everything falls apart.)

Participant 7 sets an alarm to remind herself and the mentally ill to take medication. During the first interview, P4 also had an alarm that went off every 3 hours to remind the mentally ill to eat, but she no longer uses it because the mentally ill screams whenever it goes off.

P7's testimony underscores the precarious nature of home-based caregiving in unpredictable environments. Her emphasis on routine reflects an attempt to

establish micro-control in macro-chaos, where predictable schedules mitigate the constant uncertainty of living with mental illness. The statement “izinto azihambi kahle” (“things fall apart”) highlights how fragile the balance of daily life can be without structure. Silaule et al. (2024) observed similar dynamics in South African townships, where routines reduced home-based caregiver stress by minimising unpredictability and stabilising households. For P7, the routine was not merely practical but also symbolic: it reinforced her role as a mother who brings order to chaos, reclaiming dignity in an environment marked by stigma and poverty.

Furthermore, P7’s reliance on structure underscores the cognitive relief that predictability provides. By anticipating what comes next, she reduces anxiety and prevents emotional exhaustion. This aligns with Resilience Theory, which recognises routines as psychological scaffolding that supports both caregivers and patients (Munaru et al., 2025). In Uganda, home-based caregivers reported lower rates of depression when routines were consistent, demonstrating how structure directly impacts mental health outcomes. For P7, routine serves as both a survival tactic and an identity-affirming practice, a way to demonstrate competence, care, and stability within a community that might otherwise perceive her household as dysfunctional.

During the focus group, P10 shared that she sets rules at home to ensure everyone knows what to do, making it easier to manage situations. P9, 18, and 20 agreed, but younger participants expressed frustration with having rules.

I wish I could also establish rules that everyone adheres to, but I am unable to do so. For instance, I cannot set rules for my parents, as they frequently remind me that I reside in their household and should follow their instructions. This makes caring for my brother challenging, as I establish a routine for the week, but on weeks when my parents engage in their own activities, Mondays become

particularly difficult, as my brother anticipates doing whatever, whenever, just as he does when our parents are present.

The approach of the P10S illuminates how home-based caregiving is managed not only at the individual level but also across the entire household. By instituting imigomo (rules), she redistributed home-based caregiving responsibilities and reinforced collective accountability, thereby reducing her isolation. This reflects Ubuntu-informed home-based caregiving, which perceives illness as a shared family responsibility rather than an individual burden (Nkomo, 2025). Her strategy aligns with findings from Ethiopia, where families restructured household responsibilities to support home-based caregivers, thereby reducing conflict and enhancing resilience (Munie et al., 2024).

From a feminist perspective, the P10S' actions also demonstrate resistance to the feminisation of care. By establishing rules, she challenged the expectation that home-based caregiving solely rests on women, thereby redistributing tasks among household members. This represents a form of structural coping, where gendered burdens are negotiated within the household. Naidoo et al. (2025) argue that such practices highlight women's agency in managing care environments, even in contexts of inequality. For the P10, rules served both as a coping mechanism and a political act, redistributing invisible labour and reinforcing the collective nature of care.

P14 (47, aunt):

“Uma ngibeka isimiso, ngiyakwazi ukubhekana nesimo ngoba ngiyazi ukuthi yini elandelayo. Uma kungekho isimiso, umuntu uyakhathazeka kakhulu.” (When I set a routine, I can cope with the situation because I know what comes next. Without a routine, a person worries too much.)

P14's account underscores the psychological significance of routines in managing anxiety. Predictability enabled her to "breathe" amidst the uncertainty of home-based caregiving, demonstrating the cognitive-relief function of routines. This aligns with Favina et al. (2025), who argue that structured schedules enhance resilience by reducing uncertainty and lowering emotional strain. In P14's case, routine was not only for the patient's stability but also for her own mental well-being, enabling her to sustain care over time.

From a broader perspective, P14's account illustrates how ordinary domestic order becomes therapeutic in under-resourced settings. Comparative research in Uganda indicates that routines improved home-based caregivers' sense of control and reduced depression (Hobe et al., 2025). In Clermont, where unpredictability is exacerbated by poverty, stigma, and inadequate health systems, routines assume heightened importance as self-generated forms of resilience. For caregivers like P14, structure is not merely organisation but a lifeline that safeguards against emotional collapse, enabling them to endure the daily challenges of caregiving.

6.2.2 Peer and Social Support

Peer and social support emerged as important coping resources that may be theoretically interpreted through Social Identity Theory, which explains how shared caregiving experiences foster collective belonging, mutual recognition, and identity reconstruction. Within contexts of stigma and marginalisation, these informal networks function not only as emotional support systems but also as social spaces where caregivers renegotiate self-worth and resilience.

Numerous caregivers described constructing informal networks of solidarity and mutual recognition through shared caregiving experiences, reflecting broader global patterns in under-resourced mental health contexts. Comparative caregiving scholarship demonstrates that where formal psychosocial services are limited, peer-based relational support becomes a critical survival mechanism that

enables caregivers to collectively reinterpret suffering, reinforce emotional resilience, and sustain caregiving roles despite structural adversity. These networks therefore function not only as spaces of empathy but also as socially generated coping infrastructures that compensate for systemic service gaps.

. These experiences may be further interpreted through Social Identity Theory, which suggests that shared caregiving challenges foster in-group solidarity and collective meaning-making. Peer support networks thus function not only as emotional resources but also as spaces where caregivers reconstruct identity, belonging and social worth in contexts marked by stigma and marginalisation.

Access to informal community support networks must be critically understood as both a resource and a reflection of structural insufficiency within formal mental health systems. While such networks enhance emotional resilience and coping capacity, their necessity simultaneously signals the systemic absence of sustained institutional support for home-based caregivers. In this sense, community solidarity operates as a compensatory mechanism within contexts of structural inequality, enabling caregivers to sustain care practices in environments where state and clinical interventions remain inconsistent or inaccessible.

This section delves into how caregivers construct these support systems as acts of resilience and solidarity, transforming shared adversity into collective strength within a context of limited institutional care.

P9 (29, sister):

“Ngikhuluma nomngani wami naye onomuntu ogulayo ekhaya. Ukuxoxa naye kwenza ngizizwe ngikhululekile ngoba siyakwazi ukuqonda ubunzima bomunye nomunye.” (I talk with my friend who also has someone sick at home. Talking with her makes me feel free because we understand each other’s struggles.)

P9's account illustrates the healing power of peer recognition. Unlike wider community interactions marked by stigma, speaking with another home-based caregiver validated and freed her. Similar to P9, four other participants confide in their friends when their responsibilities overwhelm them. P1 even wished her friend had stayed closer so they could spend more time together. P5 felt her friend didn't always understand her challenges and wished she could spend a week with her sick brother to see what she goes through.

This aligns with social identity theory, which demonstrates how shared experiences of stigma foster solidarity within in-groups (Goffman, 2023). For P9, peer support served as informal therapy, where mutual recognition alleviated loneliness and built resilience. In Uganda, similar peer networks enhanced the mental health of home-based caregivers by affirming that challenges were collective rather than individual (Ashaba et al., 2025).

P9's words illustrate how home-based caregivers establish "hidden infrastructures of care" in settings where formal psychosocial services are lacking. These networks, despite their fragility, provide spaces for uninhibited expression and emotional healing. From a medical anthropology perspective, they demonstrate how home-based caregivers generate social significance and solidarity in ways that compensate for institutional neglect. Comparative research in India indicates that peer groups not only reduced stress but also facilitated families' innovative coping strategies (Gupta, 2021). P9's narrative demonstrates how solidarity transforms suffering into shared resilience, empowering caregivers to continue their roles.

P11 (40, mother):

"Uma izinto zingasahambi kahle, ngithola usizo kumakhelwane. Ukuxhasana kuyasiza kakhulu ngoba umuntu akazizwa eyedwa." (When

things are not going well, I get help from neighbours. Supporting each other helps a lot because one does not feel alone.)

P11 underscores the significance of neighbourhood reciprocity in mitigating the strain experienced by home-based caregivers. Neighbourly support, manifested in practical assistance such as providing food, checking on patients, or offering companionship, reinforces Ubuntu values of interconnectedness. Her reflection on the phrase “akazizwa eyedwa” (one does not feel alone) aptly captures the emotional relief that such support provides.

In contrast, Silaule et al. (2024) discovered that home-based caregivers in South Africa valued neighbourly support, even when inconsistent, as it alleviated feelings of isolation and provided temporary respite.

However, P11 also highlights the vulnerability of such networks, which are frequently undermined by gossip and stigma. From a structural violence perspective (Farmer, 2020), the reliance on neighbours reflects systemic neglect, where informal networks supplant formal services. Comparative evidence from India corroborates that community solidarity often serves as the sole buffer against systemic care gaps (Anand, 2021). For P11, neighbourly support sustained her resilience, yet it also underscored the absence of structured, state-backed assistance. Her narrative elucidates the dual nature of social support: profoundly affirming when present but precarious and uneven when predicated solely on voluntary reciprocity.

6.3. Maladaptive Coping Strategies

6.3.1 Withdrawal and Silence

Withdrawal and emotional silence among home-based caregivers in Clermont Township may be more critically understood when positioned within broader international scholarship on caregiving stigma, psychosocial coping, and

structural marginalisation. Global research consistently demonstrates that caregivers in under-resourced contexts often adopt withdrawal as a protective strategy to manage social judgment, emotional fatigue, and institutional neglect (Ashaba et al., 2025; Munie et al., 2024). In this regard, the experiences of Clermont caregivers resonate with findings from Uganda, Ethiopia, and India, where silence has been documented as both a culturally mediated coping response and an indicator of constrained psychosocial support environments. By situating these local narratives within global debates on stigma management and resilience, it becomes evident that withdrawal is not merely an individual behavioural response but a socially produced survival strategy shaped by intersecting forces of gender inequality, poverty, and limited access to mental health resources (Kleinman, 2020; Lund et al., 2022). Thus, the Clermont findings contribute to expanding international understandings of caregiving by illustrating how silence operates simultaneously as emotional protection, identity preservation, and unintended social exclusion within structurally marginalised settings.

P5 (25, youngest caregiver):

“Uma izinto ziba nzima, ngihlala ngithule ngoba abantu bangahluleka ukungizwa. Kungcono ukuzigcina ngaphakathi.” (When things become too hard, I stay quiet because people might not understand me. It feels better to keep it inside.) Similar to p5, P7 also shared that she chooses to keep quiet and withdraws herself when her parents disregard her rules and routine.

The voice of P5 illustrates how silence itself becomes a coping mechanism, both a shield and a prison. By withdrawing, she protects herself from misunderstanding and ridicule, but she also cuts herself off from potential support. This echoes Goffman’s (2023) concept of stigma management, where silence is used to avoid further discrediting. Her silence reflects the psychological

cost of home-based caregiving as a young woman who is forced into premature emotional maturity, navigating burdens that her peers cannot relate to. Nkomo et al. (2024) found similar dynamics in South African townships, where young home-based caregivers carried hidden responsibilities, often concealing them to avoid social exclusion.

From a resilience theory perspective, P5's silence represents an adaptive yet fragile strategy. It helps her retain dignity in the short term, but in the long run, it deepens isolation and erodes emotional resilience. Studies from Ethiopia confirm that home-based caregivers who avoided conversations about mental illness reported higher rates of depression and stress (Munie et al., 2024). P5's account demonstrates how structural stigma silences young caregivers, denying them safe spaces for expression. Her coping is therefore simultaneously protective and harmful, revealing the precarious balance caregivers must strike in managing stigma, responsibility, and emotional well-being.

P13 (45, aunt):

“Ngizifihla emhlabeni ngoba angifuni abantu bacabange ukuthi umndeni wethu uhlazekile.” (I hide myself from the world because I don't want people to think our family is shamed.)

P13's testimony illuminates the pervasive stigma that extends beyond the individual home-based caregiver to the entire household. Her coping mechanism of withdrawing from public spaces served not only as a means of self-protection but also as a protective shield for her family's reputation. This underscores the dynamics of courtesy stigma, where families of individuals with mental illness are often stigmatised as socially tainted (Dlamini, 2024). Her words reflect the significant burden of family honour: disclosure could attract gossip and humiliation, compelling her to adopt withdrawal as a strategy for damage control.

From a feminist perspective, P13's silence underscores the gendered cost of caregiving. Women not only shoulder the physical labour of caregiving but also bear the emotional burden of reputation management. This invisible emotional labour further entrenches women's vulnerability. Similar findings in Uganda indicate that home-based caregivers withdrew from social spaces to protect household honour, but this came at the expense of their own health (Favina et al., 2025). P13's voice, therefore, emphasises the paradox of silence as both a coping strategy and a form of structural exclusion, reinforcing the invisibility of caregivers within their communities.

5.4 Threats and Harsh Responses

Amidst the emotional and physical exhaustion of home-based caregiving, some caregivers expressed frustration through threats or harsh verbal responses directed at the person they cared for. While acknowledging these reactions can be distressing, they reveal the profound strain and moral complexity inherent in sustained caregiving in contexts of limited support. When fatigue and emotional overload accumulate, expressions of anger or irritation can inadvertently serve as outlets for unprocessed distress. Such behaviours do not reflect a lack of compassion but rather the erosion of patience under chronic pressure. This section explores how threats and harsh responses emerge as maladaptive coping mechanisms that provide temporary relief from overwhelming frustration, coexisting with feelings of guilt, love, and moral conflict. By examining these responses through psychological, feminist, and medical anthropological lenses, the discussion illuminates the human limits of resilience and the emotional toll of caregiving in under-resourced environments.

P8 (37, mother):

“Kwesinye isikhathi ngiyamthuka ngithi ngizomshiya. Angikwenzi ngenhliziyo kodwa ngoba sengikhathalele kakhulu.” (Sometimes I scold her

and say I will abandon her. I do not mean it in my heart, but it comes when I am extremely tired.)

P8's account sheds light on the coping mechanism of venting frustration through threats, reflecting the emotional toll of home-based caregiving fatigue. Her threats were not born of cruelty but of exhaustion, a form of burnout that blurred the line between care and despair. Psychologists describe this as caregiver burnout, where prolonged stress manifests in irritability and verbal harshness. P5 is an example of this, as she shared that she often feels frustrated when other family members neglect her on weekends. She claims that as a family, they had agreed that she would take care of her aunt from Monday to Friday. This leaves her frustrated, and she finds herself being harsh to her aunt. When she states, "Sometimes I scold her and say I will abandon her. I do not mean it in my heart, but it comes when I am extremely tired," her immediate clarification that she does not mean it highlights the guilt and moral injury that home-based caregivers feel when they act outside their values.

From a resilience theory perspective, P8's words reveal the limits of endurance under relentless pressure. While she copes by releasing frustration verbally, this strategy risks damaging the caregiver-patient relationship. Nkosi (2022) similarly found that women home-based caregivers in South Africa sometimes used harsh discipline during breakdowns, reflecting the intersection of gendered burnout and caregiving strain. Globally, studies in Ethiopia (Abebe et al., 2024) report that verbal threats were common in contexts of poverty, as caregivers expressed despair without access to psychosocial support. P8's testimony illustrates that resilience is not infinite; it frays under constant strain, producing coping practices that coexist with guilt and love.

P6 (35, mother):

“Ngiyazisola kodwa ngiyavuma ukuthi ngikhuluma kabi uma engalaleli. Umoya wokukhathala uyenza umuntu aphaheke kabi.”(I regret it, but I admit I speak harshly when she doesn’t listen. The spirit of exhaustion makes a person behave badly.)

P6 attributes her frustration to umoya wokukhathala (“the spirit of exhaustion”), illustrating how coping manifests in harsh responses. This idiom externalises blame onto fatigue, illustrating how home-based caregivers culturally understand burnout as an embodied force. From a medical anthropology perspective, this language underscores the moral injury home-based caregivers feel when they deviate from patient ideals.

Her admission underscores the vulnerability of resilience in under-resourced settings. Research conducted in Botswana revealed that caregivers frequently described exhaustion as an overwhelming presence in their bodies, reflecting the embodied impact of caregiving (Sakwape et al., 2025). From a feminist perspective, P6’s experience also highlights the gendered injustice of caregiving: women are expected to endure home-based caregiving indefinitely, yet when fatigue overwhelms them, they experience guilt for failing to conform to societal expectations of nurturing. Her voice illuminates the concealed cost of home-based caregiving, the moral burden of carrying both responsibility and regret.

6.3.2 Medication Overuse

The practice of medication overuse reported by caregivers in Clermont Township can be analytically positioned within wider international discussions on improvised care strategies in contexts characterised by systemic health service limitations. Comparative studies across low- and middle-income countries indicate that family caregivers frequently modify treatment routines as a means of stabilising household environments and managing behavioural crises in the absence of adequate professional guidance or respite services (Gupta, 2021;

Rubega et al., 2025). From a global mental health perspective, such practices highlight the complex moral negotiations caregivers undertake as they balance clinical adherence with immediate survival needs. The Clermont findings therefore extend existing scholarship by demonstrating how medication practices become socially embedded coping mechanisms shaped by structural inequality, gendered caregiving expectations, and stigma-related pressures. This reinforces international arguments that caregiving behaviours must be interpreted within socio-economic and cultural contexts rather than solely through biomedical compliance frameworks (Bhugra et al., 2021; Farmer, 2020).

P12 (60, mother):

“Uma ebanga umsindo ongapheli, ngimnika imishanguzo engaphezu kwalokho okushiwo. Kungenxa yokuthi nami ngifuna ukuthula.” (When he makes endless noise, I give him more medication than prescribed. It is because I also want peace.)

P6 (same caregiver as above):

“Uma ngizizwa ngingasenamandla, ngithi ake ngimnike imithi ukuze azole. Noma ngabe ngingazi ukuthi kuhle yini, kuyangenza ngiphumule.” (When I feel I have no more strength, I just give her medication so she can be calm. Even if I don’t know if it is right, it allows me to rest.) *“Kwesinye isikhathi ngimnika imithi ngesikhathi esingekho ngoba ngiyaqonda ukuthi uma ingekho, izinto ziyaphazamiseka. Angifuni izigameko ezimbi.”* (Sometimes I give the medication at a different time than prescribed because I know that without it, things get disrupted. I don’t want bad incidents to happen.)

The voice of a P12 student illuminates how overmedication becomes a coping mechanism for home-based caregivers seeking respite. Her words emphasise the

exhaustion of constant vigilance, where silence and tranquillity are equally valued as clinical management. From a structural violence perspective (Farmer, 2020), her actions reflect systemic neglect: in the absence of psychosocial support or respite care, caregivers resort to improvising with medication. Kovane et al. (2025) discovered similar practices in Botswana, where overmedication was employed to secure rest and maintain household harmony.

Her narrative also highlights the concealed costs of home-based caregiving for older women. Carrying the dual burden of ageing and caregiving, the P12 student demonstrates how medication is not only utilised for the patient's benefit but also for the caregiver's survival. This reinterpretation of medication as a coping tool reflects the interplay of gender, poverty, and neglect, where caregivers are compelled to manage crises with limited resources.

P7 (younger caregiver):

P7's narrative elucidates how altering prescriptions serves as a coping strategy to preserve household stability. Her actions demonstrate initiative, yet they also expose the risks associated with self-management without professional guidance. Oyegbile et al. (2025) discovered that South African home-based caregivers frequently modified treatment plans to anticipate crises, a strategy stemming from necessity rather than disregard. From a resilience theory perspective, this illustrates proactive yet precarious coping that sustains stability while undermining safe medication practices.

Internationally, research in India reveals similar trends where home-based caregivers experimented with dosages to prevent crises, reflecting desperation in the absence of accessible care (Gupta, 2021). For P7, overmedication was both a form of protection against household chaos and a manifestation of structural neglect. Her narrative underscores the dangers of caregiver improvisation under systemic constraints.

This testimony illustrates how fatigue drives the coping mechanism of overmedication. Her framing of medication as a means of rest highlights how structural neglect transforms clinical treatment into a survival mechanism for the caregiver. From a feminist perspective, it underscores the injustice of home-based caregiving: women are expected to shoulder an endless burden of emotional labour without formal respite, leading to risky practices. Studies in Ethiopia exhibit similar accounts where women admitted to medicating relatives for “peace” rather than clinical necessity (Alamaw et al., 2024). P6’s words emphasise how overreliance on medication conceals deeper systemic failures, shifting responsibility from health systems onto exhausted women caregivers.

P11 (40, mother):

“Uma kuza izivakashi noma omakhelwane, ngiyashesha ngimnike imithi ukuze bangaboni ukuthi akaphatheki kahle. Angifuni ukuhlazeka.” (When visitors or neighbours come, I quickly give him medication so they do not see that he is unwell. I don’t want to be embarrassed.)

P11’s account illuminates how stigma influences coping strategies, particularly in relation to medication use. For her, overmedication was not solely about managing disruptive behaviour but also about safeguarding the family’s reputation. This aligns with Dlamini’s (2024) concept of the moral economy of stigma, wherein home-based caregivers feel compelled to conceal illness to preserve social standing. Her actions demonstrate how biomedical practices are adapted to serve social rather than clinical objectives.

This resonates with findings in Uganda, where families resorted to medicating relatives before social events to avoid gossip and humiliation (Rubega et al., 2025). From a social constructionist perspective, P11’s coping illustrates how medical practices are embedded in social contexts, shaped as much by the fear of stigma as by clinical guidance. Her narrative underscores the dual burden faced

by caregivers: not only sustaining care but also protecting their household from public shame.

6.5. Conclusion

The coping mechanisms employed by home-based caregivers of relatives with mental illness in Clermont Township reveal a delicate equilibrium between resilience and vulnerability. While adaptive strategies such as prayer, structured routines, peer support, and acceptance provide strength and continuity of care, maladaptive responses like withdrawal, harshness, and overmedication highlight the emotional toll of caregiving in contexts of poverty, stigma, and limited support. Networks of family, neighbours, and churches emerged as vital yet uneven sources of relief, while cultural and gendered expectations persisted in shaping how women navigated their caregiving roles. These findings emphasise that coping is not an individual endeavour but a socially and culturally embedded practice, profoundly influenced by structural inequalities. Ultimately, the chapter underscores how caregivers negotiate survival through everyday strategies that preserve both care and dignity, while simultaneously highlighting the pressing need for systemic interventions to support their well-being.

CHAPTER 7: CONCLUSION

7.1 Introduction

This study aimed to explore and critically analyse the experiences and coping strategies of home-based caregivers treating individuals diagnosed with mental illness in Clermont Township, KwaZulu-Natal. Employing a medical anthropological perspective, it examined how caregivers, predominantly women, navigate the intertwined realities of poverty, gendered expectations, cultural beliefs, and systemic neglect. Guided by an interpretivist paradigm and phenomenological design, the study was grounded in Social Constructionism, Feminist Theory, and Social Identity Theory. These frameworks collectively illuminated caregiving as a socially constructed, gendered, and identity-forming practice. Through caregivers' narratives, this research demonstrated that caregiving transcends its domestic or medical connotations, becoming a profoundly moral, emotional, and cultural act rooted in kinship and survival. The findings reveal that caregivers embody both vulnerability and strength as they manage care within contexts of economic hardship, stigma, and institutional neglect. This concluding chapter synthesises the salient findings, theoretical reflections, and contributions of the study, and proposes recommendations for policy, practice, and future research.

7.2 Summary of Key Findings

Plural Understandings of Mental Illness

This section synthesises the empirical insights presented in previous chapters by drawing together the interrelated themes of meaning-making, structural hardship, gendered labour, stigma, and coping. Rather than viewing these dimensions as isolated findings, the analysis demonstrates how they collectively shape caregiving experiences within township contexts. The summary therefore

provides an integrated narrative that connects local lived realities to broader theoretical and global mental health debates.

The study revealed that caregivers interpret mental illness through pluralistic frameworks that combine biomedical, cultural, and spiritual logics. For many participants, mental illness (*ukugula kwengqondo*) was simultaneously understood as a medical and spiritual condition attributed to ancestral displeasure (*ukungahloniphi amadlozi*), witchcraft (*idliso*), or social disharmony, yet also treated with psychiatric medication. This coexistence reflects the persistence of medical pluralism within South African township life (Ngcobo & Pillay, 2022; Mzimela & Zuma, 2023). Caregivers moved fluidly between clinics, churches, and traditional healers, seeking holistic restoration rather than clinical cure. This finding aligns with Kirmayer and Pedersen's (2021) argument that African healing embodies "multiple epistemologies of health." Thus, caregiving emerges as an act of cultural mediation in which caregivers bridge the boundaries between medicine, spirituality, and community belonging.

The Realities of Home-Based Caregiving

Caregiving in Clermont unfolded within deep structural inequality and minimal institutional support. Chronic poverty, unemployment, and limited access to healthcare resources defined caregivers' daily realities. Several participants reported delaying clinic visits due to transport costs, illustrating survival-driven trade-offs rather than neglect. These findings echo township-based studies (Silaule et al., 2024; Naidoo et al., 2025) that link poverty to cycles of vulnerability in community-based mental health care. Caregivers described their bodies as "sharing the illness," capturing the physical and emotional toll of continuous care. Fatigue, sleeplessness, and psychological strain characterised their experiences, revealing that caregiving is not only a social or familial duty but an embodied and health-related concern. The study, therefore, exposes home-

based caregiving as an invisible health crisis within South Africa's broader mental health landscape.

Gendered Dimensions of Caregiving

Caregiving in Clermont Township was profoundly influenced by gender norms that naturalise women's emotional and physical labour. Mothers, sisters, and grandmothers assumed primary caregiving roles, while men were largely absent. Participants noted being told that "abesifazane bayanesineke, bazobhekana nakho" ("women have patience, they will handle it"), reflecting patriarchal ideologies that equate femininity with endurance. This feminisation of care work mirrors patterns documented both locally and globally (Mbatha et al., 2024; Nkomo, 2025). Feminist analysis exposes how patriarchy moralises women's unpaid labour and silences their exhaustion. Many caregivers internalised guilt for feeling overwhelmed, perceiving fatigue as moral failure. The study thus reveals that caregiving is a gendered moral economy, one that idealises sacrifice while obscuring systemic inequity.

Stigma and Social Isolation

Stigma emerged as one of the most pervasive challenges. Caregivers were often ridiculed, ostracised, or labelled as uhlanya ("mad") or uhlanza ("dirty") by association. As one participant shared, "Abantu bayakhuluma uma bebona umfowethu, bathi 'uyahlanya,'" demonstrating how stigma is enacted through language that erases dignity. This supports Goffman's (2023) notion of "spoiled identity," where individuals are reduced to a stigmatised condition. Stigma was also institutional, manifesting in dismissive healthcare interactions and long waiting times that caregivers interpreted as disrespect. Dlamini (2024) describes this as "institutional disrespect," whereby systems reproduce social marginalisation. Spiritual spaces, too, sometimes reinforced exclusion, as some churches avoided families associated with "madness." Stigma in Clermont thus

operated across linguistic, institutional, and moral domains, deepening isolation and distress.

Coping Mechanisms and Resilience

Despite facing significant challenges, caregivers exhibited remarkable resilience. Faith and spirituality served as primary coping mechanisms, providing a sense of tranquillity and divine connection. Prayer and ancestral communication provided emotional outlets when formal support was unavailable (Khoza, 2021; Favina et al., 2025). Establishing daily routines, fostering social connections, and incorporating humour assisted caregivers in regaining a sense of control and belonging. While informal peer support within the community offered spaces for empathy and collective resilience, some caregivers resorted to maladaptive coping strategies, such as social withdrawal or emotional suppression. This aligns with Resilience Theory's assertion that resilience is dynamic and coexists with vulnerability (Muwanguzi et al., 2025). Consequently, coping in this context entails both moral and cultural obligations, rooted in duty, faith, and relational identity.

7.3 Theoretical Reflections

Social Constructionism

Social Constructionism elucidates how caregivers' perceptions of illness and care are influenced by cultural significance rather than biomedical objectivity. Caregivers constructed illness through shared community narratives that incorporate religious beliefs, ancestral convictions, and gendered morality (Hashemi & Mashinchi, 2020). In Clermont, caregiving was perceived as a moral and relational obligation, an anticipated extension of womanhood. Mental illness was not merely a diagnosis but a social event that reshaped family identity and

community standing. This theoretical perspective underscores that “care” itself is a socially negotiated practice, embedded within relationships of power, culture, and morality.

Feminist Theory

Feminist theory illuminated how patriarchy structures caregiving as unpaid and undervalued labour. Women’s perseverance was celebrated as a virtue but employed to justify systemic neglect (Mmereki & Molefi, 2025). The theory also underscored subtle forms of resistance: establishing emotional boundaries, forming support networks, and asserting decision-making authority. These acts of defiance, albeit minor, disrupted the normalisation of women’s suffering. Consequently, feminist theory reframes caregiving as both a site of oppression and of agency, wherein women transform pain into strength and silence into moral authority.

Social Identity Theory

Social Identity Theory provided an explanation for how caregivers constructed self-worth and a sense of belonging within their caregiving roles. Numerous participants derived moral pride from their perceived strength and divine purpose identities, which were reinforced by community recognition and spiritual faith (Nguse & Wassenaar, 2021). However, identity was ambivalent: caregivers experienced both honour and burden, respect and isolation.

Caregiving identity may be understood as relationally and socially constructed through ongoing processes of affirmation, stigma, cultural expectation, and structural constraint. Interpreted through Social Constructionism, Feminist Theory, and Social Identity Theory, caregiving emerges not merely as a domestic role but as a negotiated social position shaped by power relations, gendered norms, and collective meaning-making within economically marginalised

contexts. The theory shows that identity reconstruction is a form of psychological survival, transforming caregiving from an imposed role into a source of meaning.

The findings of this study contribute to broader international debates by illustrating how caregiving practices are socially constructed through intersecting cultural meanings, gendered expectations, identity negotiations, and structural inequalities that are common across diverse global contexts. When interpreted through Social Constructionism, Feminist Theory, and Social Identity Theory, the experiences of Clermont caregivers resonate with transnational evidence demonstrating that family caregiving in mental health settings is simultaneously shaped by symbolic cultural logics and material socio-economic constraints (Kirmayer & Pedersen, 2021; Lund et al., 2022). By foregrounding township-based narratives, this study extends global scholarship by revealing how caregiving roles are locally negotiated yet structurally patterned in ways that reflect wider patterns of marginalisation in community mental health systems. Consequently, the Clermont case offers a critical empirical lens through which international discussions on resilience, stigma, and gendered care labour can be further contextualised and theoretically enriched.

7.4 Contributions to Knowledge

1. Medical Anthropology:

This study explores how culture, gender, and poverty intersect to shape community mental health care in South Africa, using lived experience as a theoretical foundation.

2. Feminist Scholarship:

It highlights the structural invisibility of women's unpaid care and critiques the moralisation of their endurance, leading to gender-responsive policy and advocacy.

3. Social Identity and Resilience Studies:

This study shows how caregivers create meaning through faith and solidarity, providing new insights into resilience in the face of inequality.

4. Policy and Practice:

It provides empirical evidence for caregiver inclusion, recognition, and compensation in national mental health systems.

5. Localised Knowledge Production:

Centring Clermont Township in the study contributes to decolonising mental health research and amplifying South African township-based perspectives.

7.5. Recommendations

Policy and Institutional Support

- Implement caregiver stipends or grants to acknowledge unpaid care work as crucial labour.
- Improve primary healthcare by ensuring a steady supply of psychiatric medication and providing mobile outreach services.
- Provide healthcare worker training on cultural competence and caregiver collaboration.

Psychosocial and Peer Support

- Establish community-based caregiver support groups to mitigate isolation and promote well-being.
- Integrate faith-based and traditional leaders into mental health support initiatives, recognising the existence of diverse healing systems.

Education and Awareness

- Implement anti-stigma campaigns in schools, clinics, and media to combat harmful language and misconceptions.
- Develop caregiver education programs that focus on symptom management, stress reduction, and effective family communication.

Research and Evaluation

- Conduct longitudinal studies that track caregiver well-being, burnout, and resilience.
- Explore male caregiving experiences and intergenerational patterns.
- Evaluate the implementation of the National Mental Health Policy Framework (2023–2030).

7.6. Conclusion

This study concludes that home-based caregiving for individuals with mental illness in Clermont Township is both an act of love and a sign of systemic neglect. It is sustained by women's emotional strength, religious faith, and moral duty, yet it faces challenges from poverty, gender inequality, and stigma. Caregivers manage a complex mix of medicine, religion, and culture, turning suffering into resilience and isolation into solidarity. However, resilience should not be overly romanticised. As Farmer (2020) highlights, resilience without systematic reform continues structural violence; it sustains survival but not justice. Therefore,

recognising and supporting home-based caregivers is not just a policy matter; it is an ethical duty. By prioritising caregivers' perspectives, this study helps decolonise mental health discussions and promotes a compassionate, inclusive approach to care. Ultimately, the women of Clermont Township remind us that caregiving is a deep expression of humanity, where vulnerability and strength coexist, and where invisible labour of love upholds the moral fabric of South Africa's community mental health system.

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APPENDICES

Appendix A: Consent to Participate in a Research Study

I'm Londiwe Jabulile Simelane, a Master's student in Anthropology at the University of KwaZulu-Natal. My student registration number is 214508213.

I am conducting a study to explore the experiences and coping strategies of home-based caregivers who provide care to individuals diagnosed with mental illness in Clermont Township, KwaZulu-Natal. The objective of this study is to gain a comprehensive understanding of the daily challenges, cultural influences, and support systems that shape the caregiving role within the community.

You have been selected as a potential participant in this research study. Participation in this study is entirely voluntary. You have the right to withdraw from the interview at any time or decline to answer any questions that may make you feel uncomfortable. For this study, your comments will remain confidential unless you specifically request that your personal information be disclosed and utilised. I will make every effort to safeguard your privacy, including the use of pseudonyms and the secure storage of your data. Information collected during this study may be published in academic journals or presented at academic conferences; however, your confidentiality will remain fully protected.

Kindly be advised that participants in this research will not receive any form of compensation.

If you decide to participate in this study, you will be required to take part in an in-depth, open-ended interview that will allow you to express your experiences and feelings related to caregiving. Interviews will typically last between 45 and 60 minutes. Should there be a need to revise the interview schedule, your consent will be requested. With your consent, all interviews will be audio-recorded and subsequently transcribed.

Would you like to proceed with the interview?

YES_____. NO_____

If you have indicated a positive response, kindly complete the agreement and consent section below. Both the researcher and the participant will sign a copy of the document.

Consent Form

I, the undersigned, hereby acknowledge and consent to take part in the study outlined below.

Study Purpose and Procedures:

I have reviewed and understood the objectives and procedures of the study.

Voluntary Participation: I have made a voluntary decision to participate in the study

Withdrawal Rights: I keep the right to withdraw from the study at any time without incurring any penalties.

Confidentiality: I am committed to maintaining the confidentiality of my personal information during the study.

Participant Information:

Name: _____

Signature: _____

Date: _____

Researcher Information:

Name: Londiwe Jabulile Simelane

Signature: _____

Date: _____

Appendix B: Interview Guide

Note: These are open-ended questions. They will not necessarily follow a strict order and will be posed within conversational interactions or informal interviews.

This study delves into the experiences, challenges, and coping strategies employed by home-based caregivers who provide care for individuals diagnosed with mental illness within Clermont Township.

Name: _____

Age: _____

Gender: _____

Relationship to the individual with mental illness: _____

Years of experience as a caregiver: _____

Interview Questions

1. Could you elaborate on your responsibilities as a caregiver for your relative or loved one who has a mental illness?

2. How do you comprehend or define the role of a home-based caregiver within your household or community?

3. Could you please elaborate on how you initially assumed the role of a caregiver?

4. Could you please provide a detailed list of the daily tasks you undertake while caring for an individual with a mental illness?

5. What challenges do you face when providing care?

(e.g., emotional strain, financial difficulties, stigma, lack of support, safety concerns)

6. How has caregiving impacted your personal life, relationships, or professional pursuits?

7. What obstacles do you encounter when attempting to obtain mental health services for your relative?

8. How do stigma or community attitudes impact you or your family?

9. What coping mechanisms or strategies do you employ to manage the stress associated with caregiving?

(e.g., prayer, humour, social support, routine, traditional healing, withdrawal, resilience)

10. Are there any spiritual, religious, or traditional practices that assist you in coping with caregiving responsibilities?

Who provides emotional or practical support in your caregiving role?

(Family, neighbours, church, clinics, support groups)

11. Do you believe the healthcare system adequately supports you? Provide reasons for your assessment.

12. What kind of information or training would you like caregivers to receive?

13. How can one sustain motivation and maintain hope during challenging periods?

14. If you had the opportunity to make any modifications to the mental health services or community support systems, what specific changes would you propose?

15. Could you please elaborate on any additional experiences you have had as a caregiver?

Thank you for your time and attention

Appendix C: Ethical Clearance Certificate



02 September 2024

Londiwe Jabulile Simelane (214508213)
School of Social Sciences
Howard College Campus

Dear LJ Simelane,

Protocol reference number: HSSREC/00006974/2024

Project title: Exploring the experiences and coping practices of home-based caregivers treating persons diagnosed with mental illness in Clermont township, KwaZulu-Natal

Degree: Masters

Approval Notification – Full Committee Reviewed Protocol

This letter serves to notify you that your response received on 27 August 2024 to our letter of 13 June 2024 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

Incidents of adverse events and serious adverse events (AEs and SAEs) should be reported in writing to HSSREC, the study sponsors, and any regulatory authority (where appropriate), within 7 working days of the occurrence for local sites and 14 days for all other South African sites.

This approval is valid for one year until 02 September 2025

To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

HSSREC is registered with the South African National Health Research Ethics Council (REC-040414-040).

Yours faithfully



Professor Dipane Hlalele (Chair) /nng

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