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**The impact of illness and death on
migration back to the Eastern Cape.**

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Abstract

This paper examines the impact of HIV/AIDS related morbidity and mortality on return migration to the rural Eastern Cape. The paper begins by discussing the inter-relation between population mobility and HIV and grounds these dynamics within the structural context of underdevelopment in a former homeland region of South Africa. The changing migratory regimes of the post-apartheid era, which have seen formal male labour migration supplanted by increasingly informal and feminized migratory trajectories, between both rural-urban and intra-rural locales, are described.

Five case studies are presented, and the multiplicity of factors associated with rural return migration in the face of HIV/AIDS related illness delineated. The empirical material suggests illness-induced back migration is driven not only by the search for health and succour, but also by complex amalgams of shifting entitlement and obligation. Understanding the dynamics of rural return requires attention not only to the highly variegated position that urban returnees potentially assume within receiving households, but also the effects of their return on these households. Even within the relatively limited number of case studies presented, rural returnees are variously subjects or dispensers of care, either relatively peripheral or crucially central members of receiving households. The evidence simply belies any notion of unidirectional rural return, driven by a universal set of imperatives in response to illness.

The discussion section of the paper elaborates on various salient dimensions of rural return, including local practices of caring, health-seeking, and death and dying. The management of stigma and denial that pervades each of these domains, and the decision making and constituting of personal agency by the ill, are both carefully considered. Ill-returnees engage with the search for health and an expansive range of treatment modalities in highly differential ways, accordingly their relationship with the local primary health care infrastructure ranges from embracement to eschewal. Rural return in the context of chronic terminal ill health also reflects social practices surrounding death and dying, which the paper suggests to be underpinned not only by notions of social and cultural appropriateness but also pragmatic concerns around managing the cost of funeral arrangements. The paper concludes by extrapolating from the discussion and elaborating on the dense social networks and dynamics within which ill returnees are incorporated.

1. Introduction

This, the second in a sequence of three papers, seeks to understand the impact of adult illness and death on back migration to the rural Eastern Cape. The first paper (*The dynamics of household formation and composition in the rural Eastern Cape*) (Neves & Du Toit, 2008) examined patterns of household making and migration in the context of the impoverished rural Eastern Cape, and provided the broad context in which the present inquiry is situated. The current paper examines the illness-induced rural return migration of household members, and how mobility interfaces with a range of contextual factors, household and social dynamics. The third and final paper in the series (*The consequences of AIDS related illness or death on households in the Eastern Cape*) (Neves, 2008), considers the impact of prime age adult morbidity and mortality on rural households quite specifically. The concerns of the present paper are intertwined with those of paper that follows (paper three), but the present paper is orientated to understanding illness-induced migration, and how chronically ill individuals and their households make decision and agency within the research context. The final paper is more focused on the post-migratory period and consequences of illness. As such, it is concerned with how household members respond not only to HIV/AIDS induced morbidity, but quite specifically mortality.

The structure of the present paper is as follows. Firstly the interrelation between migration and HIV is discussed before the salient elements of the research context are briefly recapitulated from paper one. These are described in terms of the three-tier typology of structural, household and individual levels, they provide a context in which to consider the impact of prime age adult morbidity and mortality associated HIV/AIDS on rural households. Following which migration, HIV, the social networks that enable rural life, and the place of decision making are described in some detail. The paper then moves to describe the methodology of the study, and presents five case studies. It concludes with an extended discussion of the findings.

2. HIV/AIDS and population mobility

Africa has 10% of the world population but two-thirds of HIV positive people globally. In South African HIV rates soared in the mid 1990s, with between 5.3 and 5.5 million people currently infected (Crush, Frayne & Grant, 2006). National HIV rates amongst adults (aged 15-49) have been in the region of 20% for several years (UNAIDS, 2007). Antenatal HIV sero-prevalence rates suggest

that infection rates may be plateauing from, 30% in 2005 to 29% in 2006 (UNAIDS, 2007). In addition, there are substantial regional variations, from 15% in the Western Cape to 39% in KwaZulu-Natal (Department of Health South Africa, 2007). Within the focal district in the Eastern Cape, HIV rates are in the region of 30% (Barron et al, 2006).

The morbidity and mortality associated with HIV/AIDS has particularly deleterious effects on human welfare, weakening affected household's economic status and their ability to sustain a livelihood. The adult mortality associated with HIV also serves to increase mobility, elevates the risk of household dissolution and serves to reshape household composition. For example, prime age adult mortality leads to more vulnerable skipped generation household forms (grandchildren with grandparents). In paper three the epidemics' pervasive and multidimensional impacts in rural life (Gillespie, 2005) are considered in more detail, the focus of what follows is on understanding HIV/AIDS in relation to population mobility.

Historically HIV/AIDS research has been highly influenced by biomedical and epidemiological approaches, and much enquiry until the 1990s was concerned with aspects of health provision, behaviour change and individual risk (Campbell & Williams, 1999). A growing scholarship, and sustained impetus on intervention, saw the focus enlarged to consider the social and economic dimensions of the epidemic. In developing society contexts this work has sought to emphasise the structural dimensions that predispose people to infection, and the upstream linkages and factors that mediate the epidemics effects (Weigers, Curry, Garbero, & Hourihan 2006; Morton 2006). Many commentators accordingly came to suggest HIV/AIDS ought to be best viewed in developmental rather than narrowly epidemiological terms, thereby entailing a shift in focus from abstracted individuals, to communities and social groups (Edström et al., 2007). In the context of sub-Saharan Africa, Barnett & Whiteside (2002) have drawn attention to the macro-structural context of HIV, while Farmer & Connors (1996) cast the social antecedents of HIV risk in terms of 'structural violence'. Yet the concept of structural violence is a blunt instrument, which potentially "loses definition and explanatory power in empirical micro-studies" (Dilger, 2006, p. 111). Hence, there remains a need to understand the epidemic in context of its micro level social and cultural factors. It is this endeavour in which the current paper, and the paper that follows, are situated. They examine the impact of HIV/AIDS on migratory dynamics within a specific resource poor rural African context.

3. Livelihoods in the rural Eastern Cape

The research was conducted in the former Transkei region of the Eastern Cape, a rural region that has a long history of underdeveloped and adverse incorporation into the larger South Africa political economy. In paper one, the overarching structural context historically patterned by over a century of oscillatory male urban migrant labour and low levels of agrarian production were discussed, as were the more recent agrarian and economic changes of the last three decades, which have reconfigured rural livelihoods, migratory pathways and household dynamics. In the first paper, these changes were explicated in terms of the twin forces of de-agrarianisation and deindustrialisation. De-agrarianisation is “the long term processes of occupational adjustment, income-earning reorientation, social identification and spatial relocation of rural dwellers away from strictly agricultural-based modes of livelihood” (Bryceson & Bank, 2001, p. 13). Although evident throughout much of the African continent its effects are arguably most strongly felt in South Africa – a nation with the continent’s most advanced industrial economy, entrenched patterns of migrant labour and highly commoditised agro-food systems. In addition, it was suggested the loss of unskilled industrial employment in stagnating industrial and manufacturing sectors (viz. de-industrialisation) sees receding prospects for rural back investment, and is similarly contributing to the reconfiguring of many rural livelihoods. Present day rural livelihoods are supported through urban remittances, some subsistence agriculture and, increasingly, the cash transfers of state welfare grants (Ardington & Lund, 1995, Barrientos & Lloyd-Sherlock, 2000)

These overarching structural factors, elucidated in paper one, furthermore serve to reshape rural social relations; for household level livelihoods and activities need to be explicated in relation to the larger structural context. Much smallholder agrarian production, is profoundly mediated by social reciprocity including: communal work parties, the pooling of draught animals, the collective deterring of livestock from crop fields and the deployment (prior to the advent of compulsory mass schooling) of children to tend livestock. Evidence suggests that the highest smallholder maize outputs in the former Transkei to be in relatively geographically isolated areas that evidence a general commitment to a ‘traditional’ Xhosa cultural precepts and identities (McAllister, 2001). The changing political economy of South African countryside is therefore intertwined with the changes in socio-cultural practices and social relations that facilitated rural livelihoods in the past. Bryceson, Fonesca & Kaczandira (2006) discern the manner in which these structural changes drive a ‘proletarianisation’ of rural dwellers so, concomitantly, “There is also a move from household towards individualised work, whereby every able-bodied person works,

including women and youth, need to earn cash to cover their subsistence needs” (Edström et al., 2007, p.15). In the ‘occupational scramble’ that accompanies de-peasantisation of rural livelihoods many formerly unremunerated activities such as beer brewing, hair plaiting, handicrafts, midwifery and even (as will be suggested later) caring for the ill, become commoditised and monetised (Bryceson & Bank, 2001).

The shifting economic base and social order underpinning rural livelihoods is intertwined with the HIV epidemic. Drinkwater (1992) argues that the twin forces of de-peasantisation and de-agrarianisation associated with changing rural livelihoods are accelerating under impact of the epidemic. Furthermore, the relationship is fundamentally circular and mutually reinforcing. The risk of HIV/AIDS is elevated by monetisation, commoditisation, the proliferation of migrant networks, within a structural context of underdevelopment (Crush, Frayne & Grant, 2006). HIV rates throughout the region have historically been shaped by population mobility. They are highest along transport corridors, and areas with transient, migratory or seasonally mobile populations. Unsurprisingly then, regional HIV rates are highest in the most affluent nations (such South Africa, Botswana), rather than most impoverished and underdeveloped (e.g. Mozambique). Dilger (2006) accordingly argues the impact of HIV in Africa be conceptualised not as the failure, but rather an outcome of modernisation and globalisation. In sub-Saharan Africa HIV/AIDS therefore represents less a consequence of atavistic underdevelopment than a phenomenon intertwined with the very conditions of material development itself. Against this structural backdrop, the present paper turns to examine the place of contemporary migration on HIV.

4. Householding and migration in the rural Eastern Cape

Paper one (Neves & Du Toit, 2008) described processes of rural household formation and sought to locate contemporary migration dynamics. It suggested that black South Africa households have a fluid and dynamic quality, described by various commentators as stretched or multi-locational. It was further suggested that definitions of households, householders and householding need avoid the habits of thought which conceptualise households and ‘families’ as necessarily stable, coherent or unitary entities. In addition to being a shorthand for the functional characteristics embodying elements of production, reproduction and consumption (Ross, 2003), it was argued that household units should not simply be seen as domestic aggregations of individuals, but rather as

dynamic social practices, unfolding local micro-projects, constituted in space and time (Neves & Du Toit, 2008). Accordingly conceptualising households demands attention both to the prospective goal or teleological 'life project' of the household, along with patterns (and the loci) of local decision-making. Processes of household formation and composition invariably straddle a range of diametrically opposed poles including: individual and collective, desire and brute contingency, change and tradition, entitlement and obligation, present exigencies and the uncertainties of the future.

Patterns of household formation and composition have a strong spatial dimension and frequently entail population mobility. Oscillatory male rural-urban migration has a century long history in Southern Africa. Much of the former Transkei was incorporated into regional migratory pathways, connecting it to the Western Cape Province and the industrial heartland of the Highveld. Internal migration patterned by the 'development cycle' of rural householding, whereby young adult men (and young adult women, to a lesser extent) out-migrated for urban employment. In the past working age adults would retire to their rural homesteads at the conclusion of urban employ, and the rhythm of migration and household formation be re-enacted by the next generational cohort. However internal (viz. 'intra-national') migration, and the range of push and pull factors that drive it, have been somewhat attenuated by the political and economic changes of the last two to three decades. While urbanisation has soared since the mid-1980s collapse of apartheid-era influx control, the political transition of the early 1990s did not precipitate a mass urban transition. Instead, the previous paper (Neves & Du Toit, 2008) suggested, the period from the early 1990s to the present, several varieties of migration are discernable, particularly along the nation's populous eastern seaboard. Firstly, oscillating rural-urban migration continues, albeit increasingly informalised and feminised (Casale & Posel, 2002; Collinson & Wittenburg, 2001; Collinson, Tollman, Kahn & Clark, 2003). A second variety of internal migration is more complete urban resettlement, but pervasive economic insecurity, coupled with a desire to provision for livelihood shocks and eventual lower-cost retirement living; many African urban residents remain orientated towards eventual rural return. A third variety of internal migration, often undertaken by women, is intra-district or intra-provincial migration. Many rural households have relocated within districts to villages or the peripheries of small rural towns that have comparatively better access to transport, communication links and infrastructural development. It is in this post-apartheid demographic landscape, that the interaction between population mobility and HIV needs to be viewed.

5. Migration and HIV/AIDS

Unlike the virulent pandemics of recorded history, such as smallpox, bubonic plague or Spanish influenza, the HI virus is not particularly communicable. Crush et al. (2005) cite evidence to suggest that in the absence of population mobility, HIV could be expected to advance spatially at a rate of approximately ten kilometres per year. The rapid growth in population mobility has therefore contributed significantly to the spread of HIV/AIDS. In the Southern African context, with its established patterns of circular labour migration, the relationship between mobility and illness has been long understood: including the role of migrant mine workers as vectors of tuberculosis (Packard, 1987), and the vulnerability of unaccompanied male migrants to sexually transmitted diseases (Kark 1947). In epidemiological terms migrants move across 'prevalence gaps', spatial zones with dissimilar disease prevalence, control measures and health facilities. More recent research, linking epidemiology to demography, has even suggested urban migrants have elevated susceptibility to non-communicable degenerative 'lifestyle' diseases such as various hypertensive, diabetic, cardiovascular and malignant ailments (Roux & van Tonder, 2006). In the case of communicable or infectious illness, migrants can serve as 'bridges' between disparate populations.

That population mobility supports the spread of HIV is explicable in a number of ways (Crush, et al. 2005). Firstly, less inhibited by familial or social mores urban migrants are more likely to engage in high-risk behaviours such as have multiple or concurrent sexual partners. However, migration is not simply a vector of disease; it is a marker of vulnerability and migrant communities are often marginalised in economic, social and political terms (Zuma, Gouws, Williams & Lurie, 2003). Migrants are transient and difficult to reach with health services, information, condoms etc. The relationship between migration and HIV is the reason why HIV infections are disproportionately clustered amongst transport corridors, border towns and amongst highly mobile populations such as itinerant traders, seasonal workers and truck drivers. This is why migrant men are 2.4 times more likely to be HIV positive, than their non-migratory counterparts are. (Lurie, Wilkinson, Harrison, & Karim, 1997)

6. Migratory responses to HIV/AIDS morbidity

The manner in which migration elevates vulnerability to HIV infection has been suggested. It is in these terms that the directionality of infection - from urban to rural - has conventionally been understood. As robust health is often a

precondition of migration, rural out-migrants are effectively ‘selected’ for their health. However, the converse dynamic can equally apply: ill health may precipitate return migration. Particularly in a context of circular migration, rural return may represent an *ex ante* response to HIV morbidity.

Illness induced migration, may be characterized by a wide range of reactions, including various care and health seeking behaviours, attempts to access health facilities that are perceived (perhaps correctly) to be of superior quality (MacPherson & Gushulak, 2001), efforts to avoid or control illness-related stigma or even migration in anticipation of death Urassa et al. (2001). In terms of conceptualising the relationship between migration and HIV/AIDS the focus of this paper is on the latter (migration as a consequence of ill health), rather than on the former (ill health as a consequence of migration). The third and final paper examines the consequences of HIV/AIDS morbidity and mortality, including the out-migration of uninfected or asymptomatic household members.

Before proceeding to understand HIV/AIDS in relation to migration, it is useful to reflect on the data weakness of the two constituent components of the problematic: HIV/AIDS and migration. With regards to migration, household surveys and census data predominate in efforts to theorise migration and population mobility in South Africa; household surveys typically capture the ‘absence’ from home, and census data the ‘change in residence’ of long-term migratory men. However the (frequently) short-term movement of women is analytically far more elusive (Hosegood & Ford, 2003), as is children’s migration, which is often patterned by parental (particularly maternal) migration (Hosegood & Ford, 2003). The paucity of appropriately detailed longitudinal data means the mobility of these groups and the more rapid frequency of their migration spells can elude all but the most detailed of enquiry. In addition, there are complex interactions between the mobility of rural residents and various household level dynamics (such as shifting, porous and even partial forms of household membership).

Apart from the lacunae surrounding migration data noted above, much HIV/AIDS orientated inquiry is of a static, cross-sectional variety rather than a longitudinal design.

Crush et al. (2005) accordingly offer the following evaluation,

“HIV/AIDS is a crucial public health priority in many African communities and many existing survey and census datasets fail to provide the kind of data needed to examine issues such as: the role of migration in the transmission of HIV, the impact of HIV/AIDS on labour migrants and the livelihoods of their rural households, and the

additional burden of rural health services imposed by returning nonresidents” (p.23).

In the existing data it is the HIV/AIDS knowledge, behaviours and risks of male migrant (often industrial) workers that are best documented, while “...epidemiological studies have neglected to focus on migrant women” (Crush et al., 2005, p.29).

In seeking to understand illness induced back migration, the following points can be made. Firstly, both popular and formal research narratives of unidirectional illness-induced urban-rural back migration are conceptually confounded by the variety of migration types (viz. rural-urban oscillatory; urban transition; intra-district rural). These three schematic categories of post-apartheid migration (and the ideographic variation of the specific migratory trajectories described in the case studies later) quite firmly belie any simplistic formulation of urban-rural back migration. This conceptualisation of the unidirectional migration and illness reflects the dichotomous terms in which the relationship between African town and countryside is often understood and articulated. Discourse concerning the relationship between these locales is frequently inattentive to the historical interdependencies between urban and rural, as sources of succour, livelihoods and identities. James (2001) furthermore observes the pervasive “perception of two worlds as separate and discrete, having been constructed through a process of reciprocal interaction, is shared by actors at both village and government level” (p. 94). If migratory dynamics are implicitly thought of in terms of the binary of urban risk and rural vulnerability, it is partially attributable to the fact that the differences between town and countryside are frequently cast in these terms.

Secondly, meta-narratives of unidirectional HIV infection and inevitable rural-return migration studies are challenged by empirical evidence of seropositivity status discordance amongst migrant couples. Seropositivity discordance (i.e. only one but not both partners are HIV positive) amongst migrant couples reveals that in 29% of cases it is the rural based female alone that is HIV positive (Thereby ruling out her regular, self-identified, partner as the vector of her infection). This challenges quotidian notions of a simple male migrant urban-rural transmission of HIV, and points to a rural dynamic in HIV infection. It furthermore suggests vulnerability to HIV infection is not a quality that inheres exclusively in migrant receiving areas (Lurie, 2000).

Finally, in light of the persistence of fluid household composition and oscillatory rural urban migration in South Africa, illness-induced return migration needs to be understood as one part of the larger arc of rural return migration. While the

empirical material presented later in this paper examines various dimensions of this dynamic in detail, distinguishing illness-induced migration from migration quite generally, remains an analytically difficult task. These issues are reflected on more comprehensively in the methodology section, but before this can be done the social and household level dynamics that support rural livelihoods are discussed in more detail.

7. Social reciprocity

Having considered the structural context and dynamics of the research setting, migration and its relationship to HIV/AIDS this paper now turns to examine social networks in this setting in more detail. Most rural households are multi-active and spatially dispersed, this allows them to distribute risks and capture livelihood-making opportunities (Jamal & Weeks, in Crush & Frayne & Grant, 2006). Furthermore, households transact within networks of social reciprocity; networks which are key to rural livelihoods and food security. Although social reciprocity is often kin mediated, several other conduits of sociality exist, including clan, geographical proximity and forms of affiliation, such as voluntary religious groups. Patterns of social reciprocity can moreover be steeped in long histories and temporal trajectories that can endure inter-generationally, beyond the span of a single individual's life. In the context of geographically dispersed livelihoods, these entail a process of provisioning for infirmity, incapacity or eventual rural retirement. As suggested in paper one, cycles of migration, employ, and rural return, often have an age graded quality, and are conventionally associated with notions of the 'development cycle' of successive generational cohorts.

In addition, social reciprocity bound up with the enactments of propriety and social respectability, essentially the need to demonstrate one's eligibility as a worthy recipient of support. The moral calculus of social obligation and entitlement moreover frequently has a strongly enforced characteristic, and as suggested in paper one, the disavowal of social obligation is similarly loaded with ideological signification. In a study focusing on household experiences of HIV-related illness and AIDS death Hosegood et al. (2007) note "Several respondents felt strongly that their impoverished circumstances deterred people from visiting or helping them out, and that poverty exacerbated the stigma around HIV and AIDS" (2007, p.1253). In these cases, the nexus of stigmatised illness and poverty effectively undercuts the ability of household members to make claims on others, thereby eroding the household's social 'transactability'.

This notion of social networks and reciprocity is sometimes cast in the rubric of social capital. Although not entirely uncontested (Fine & Green, 2000), the notion of social capital is of some utility. The register of social capital focuses attention on the context and terms of entitlements, a key domain in which vulnerability can be understood (Sen, 1999). The mediating effects of social capital on HIV/AIDS risk behaviour are illustrated by Campbell, Williams and Gilgen (2002). Drawing on a formulation of social capital as the ‘generalised trust’ flowing from civic engagement and social cohesiveness (see Putnam, 2000), it was operationalised in terms of membership of voluntary community organisations. The study reportedly yielded a variety of significant results yet “not all in the hypothesized direction” (Campbell et al., 2002, p.41). Although some forms of associational membership are associated with reduced HIV risk behaviours, membership of stokvels (mutual savings societies) coincides with higher levels of alcohol consumption, women more likely to have casual sexual partners and men more likely to be HIV positive (relative to non-stokvel members, presumably with commensurately ‘less’ social capital). The directionality of causality is unclear, but associational life hardly appears to here be a protective factor - all of which speaks of the need to disaggregate social capital and understand the particularities of vulnerability.

Some argue that the workings of ‘social capital’ are far more ambiguous, socially differentiated and dynamic than has traditionally been described (Du Toit, Skuze and Cousins, 2007). Sociality and reciprocity is traversed by the workings of power and incorporates its subjects in highly differential ways. For instance Campbell & Williams (1999) emphasizes that in terms of its impact on health social capital is neither homogenous nor equally shared, instead it is shaped by factors such as age, gender, socio-economic status, and ethnicity (Campbell et al, 2002). In addition, social capital is dynamic and constantly being recreated and reanimated. The requirements of accruing social capital significantly mediate material relationships, with commentators suggesting the centrality of ‘private social protection’ (Du Toit & Neves, 2006) to the livelihoods of the economically impoverished and vulnerable. This is not a rejection of social capital, simply an argument for a more nuanced understanding of the mediatory influence of social relations.

8. Decision making and ‘coping’

Up to this point the overarching structural context was described, following which the intermediate level of household-level networks and the social reciprocity that mediate health and livelihood shocks were considered. The present section now turns to examine the place the micro level of individual

decision making, or what Webb (1997) delineates as the realm of ‘agency’ in this three tier typology used to understand the effects of HIV. This typology maps neatly to the three-tier typology of macro-structural context, household level dynamics and decision-making, explicated in the first paper (Neves & Du Toit, 2008).

The brief history of HIV/AIDS research and intervention recounted at the beginning of this paper described how the first decade of HIV/AIDS work was epidemiologically orientated. Following which the focus shifted to examine the psychosocial, social and structural determinants of HIV risk behaviour. Attention within this perspective shifted to examine the upstream determinants of the epidemic, within which the rubric of ‘decision-making’ is typically concerned with understanding the major vector of transmission, namely sexual behaviour. HIV/AIDS theorising and intervention has subsequently been increasingly concerned with the ‘downstream’ consequences of HIV. Accordingly, the present inquiry is focused on decision making in the context of migration and HIV/AIDS related morbidity and mortality. Particularly in developing society contexts, where HIV/AIDS infection and mortality rates remain high and the opportunities for effective treatment scanty, the rubric of ‘coping’ and ‘coping mechanisms’ encodes aspects of decision making and the psychosocial dimensions of responses to HIV/AIDS. The ‘coping’ concept has been subject to critical reappraisal by several researchers (cf. Rugalema, 2000; Loevinsohn & Gillespie, 2003) - the terms of their critique implicitly suggests how the exercise of individual agency and decision-making might be evaluated. This is considered in what follows.

Firstly, the register of coping embodies the suggestion of acting in accordance with a preformulated plan or strategy (Rugalema, 2000). Yet in practice, coping and patterns of decision-making can often be marked by a contingent and *ad hoc* quality. Decision making, particular in the face of marked, livelihood threatening shocks, may be far less orderly, rationalistic and amenable to neat typologies than is conventionally supposed. While some have recast ‘coping’ in a slightly less voluntary register of ‘response’ (Loevinsohn & Gillespie, 2003), the fundamental problem endures.

Secondly, considerations of coping often encode the dominant Western picture of personhood whereby cognition emanates from the consciousness of the single, embodied individual. This bias can serve to obscure the often ‘distributed’ and communal nature of much decision making (Cole and Engeström, 1996). Rugalema (2000) rhetorically asks, “Should we talk of households, individuals, therapy-management groups, or even community with reference to strategies invoked in confronting illness?” (p. 541). In this

formulation, the locus of decision-making goes beyond the single individual. In light of the fluidity, contingency and contestation which often underpin the household, decision making often extends beyond the hypothesised and homogenous, single household.

Thirdly, positive assessments of decision making and ‘coping’ are often highly dependent on the particular time frame invoked. An event, which at first may appear to be an example of the adaptive coping, may prove, within an enlarged temporal frame, to be a gradual downward trajectory. The presumption of sustainability implicit in much of the discourse of coping and decision-making can furthermore obscure the long-term costs of short-term survival. For example, the acceptance of chronically ill or illness-displaced kin into an impoverished household may occur without the adverse effects of the elevated dependency ratios being apparent, particularly in the short term. A further, concrete example of the vicissitudes of household fortunes over time is contained in the case study of Matibane orphans recounted in the first and final papers (Neves & Du Toit, 2008; Neves, 2008). Having reconstituted their dissolved household, with receipt of two foster care grants, the sibling’s household is likely to undergo substantial changes when the grants lapse (when the recipients cease to be legal minors). Attention to decision making therefore needs to be mindful of the longitudinal trajectories within which it occurs.

This inquiry consequently seeks to understand the contextual factors that shape decision-making, and locate them in the dense matrix that constitutes context. The focus on decision making therefore needs to locate it against the backdrop of the manifold opportunities and constraints that research participants continually negotiate. Decision making in the context of chronic mortality and morbidity, and complex systems of livelihood making is invariably explicable in terms of multiple levels of analysis and profoundly ‘over-determined’. In other words, while HIV/AIDS typically constitutes a significantly individual and household level shock, its effects are neither homogenous nor are they met by a universal set of responses or imperatives. The current inquiry can therefore hardly purport to be exhaustive in its delineation of these. Instead, it describes the antecedent to and patterns of migration, in the context of HIV morbidity and mortality as commonalities and points of divergence are identified. Before the methodology is described, health systems and HIV in the focal research context are described in detail.

9. Research context: Health, health systems and HIV/AIDS in the former Transkei

The Eastern Cape is amongst the poorest province in South Africa, a status reflected in developmental and health indices that are amongst South Africa's lowest. Its seven million residents have relatively poor access to services, while regional antenatal HIV rates hover at 30%. Provincial stillborn and perinatal mortality rates are amongst the nation's highest, at 39.3 and 54.7 per 1000 births respectively.

The state health system is organised within districts, each consisting of primary health care facilities at village level that provide screening, the treatment of more manageable ailments as well as monitoring. These village based facilities refer to district hospitals in the local towns, hospitals within the district can, in turn, refer patients to a tertiary hospital in the regional centre of Mthatha. Health systems indices, such as bed utilization rates and clinical workload for nurses, are below national norms and suggest systemic inefficiencies (Barron, et al. 2006) that reflect the region's legacy of disadvantage. In the district in which the focal research setting is situated, only two-thirds (66.8%) of births occur in health facilities (Barron, et al. 2006).

There is a recent history of community involvement in health systems, as support group members, clinic committee members, home-based carers, child carers, peer educators, food distributors, income generating project members and community development workers (Friedman et al., 2007). Within the focal research setting, like many others, there is a cadre of locally based community health workers (CHWs), or village health workers (the terms are often used interchangeably), termed *nomakhayas* in isiXhosa. CHWs provide various ancillary services, intended to complement existing primary health care services. In practice much of their daily efforts are devoted to liaising between ill villagers and clinic sisters, summoning patients, running errands such as collecting sputum samples, and arranging clinic queues.

In the context of a rising HIV/AIDS burden, CHWs play a relatively limited role in preventative initiatives and are increasingly orientated to provide care and support services to HIV/AIDS affected individuals. They identify clients in need of treatment and help monitor adherence and side effects. Programmes such as DOT (Directly Observed Therapy) for tuberculosis has long relied on community members to secure the necessary patient compliance, even if district TB cure rates remain low (35.9% in 2004), poor even by national standards (Barron et al., 2006). Friedman et al. (2007) argue, "Their role is most notable in

resource poor setting where health and social services are inadequate, poverty is endemic and HIV & AIDS challenge community resources and their ability to cope with the burden of care”. Yet despite the prominence of CHWs as the first tier in a system in the public health system, they are of “uneven competence and relevance” (Friedman et al., 2007), and some argue contribute to the fragmentation of health services. CHWs are poorly qualified (often with little more than a short course) and often unremunerated. Many work for years as ‘volunteers’ in anticipation of receiving a small salary or stipend (Friedman, et al. 2007).

Two privately remunerated sets of health providers are also drawn on by residents in the former Transkei. The first are private medical practitioners found in most of the larger towns in the region. Geared to serving frequently impoverished patients without health insurance, these doctors typically dispense medication as part of a single all-inclusive consultation fee. The need to carefully control the costs of medication constrains the quality of treatment, *vis a vis* what could be offered to middle class or insured patients. Although the transport costs of travelling to town, and the consultation fees charged, can represent a large proportion of many rural residents’ monthly income, many express a preference for these medical practitioners. They are perceived to offer a higher quality care, and often have shorter waiting times than public health facilities.

The third and final health modality is the realm of traditional medicine. The traditional healing encapsulates traditional herbal remedies dispensed by an herbalist, or consultations with a traditional spiritual healer (sangoma) where treatment is “directed at the remedial reworking of the patients social relations to attain spiritual balance” (Bryceson, Fonseca & Kaczandira, 2006). These herbal remedies and spirit healing can merge in practice or even in the person of one practitioner. Finally, the three health domains described above - the district based public health system, private medical practitioners and traditional healers - are often accessed in highly syncretic ways. It is not uncommon to find patients seeking to access one or more of these treatment modalities concurrently, or working their way through a sequence of them.

In terms of HIV/AIDS treatment ARV take up is extremely low, under 100 000 people of the half a million people who need ARVs are receiving them (Robins, 2005). Where they are taken, these drugs are collected monthly or bimonthly from urban-based facilities. Entry into an ARV programme requires a ‘treatment supporter’, and attendance at training, following before the medication is dispensed. Many of the factors that predispose people to HIV infection, such as migration, gender inequality and violence, and adverse socio-economic

conditions, similarly constitute barriers to accessing treatment. These include difficulties accessing transport, the necessity of making multiple trips for adherence training, and collecting medication. Socio-economic constraints pattern poor adherence rates through the want of money for transport, food and basic services such as potable water (Padarath et al. 2006). Other barriers include “poor treatment by health facility staff, inability to apply without a 13-digit bar-coded identity document, long delays between application and receiving treatment, and extensive waiting lists.” (Padarath et al. 2006, p. 99). These constraints are all in addition to the working of denialism and stigma.

Stigma is not only widespread in everyday life; it can be associated with visiting particular health care facilities, especially VCT and ARV dispensing sites. Receipt of food parcels or feeding formula, can similarly prompt indirect disclosure. As local clinics are the unavoidable referral gateways to other public health facilities, consulting private medical practitioners can be a gambit to avoid HIV/AIDS stigma. Health seeking activities therefore entail complex sequences of accessing treatment in a context with high levels of denialism and stigma. Finally, it is useful to reflect the gendered face of treatment; higher levels of women accessing treatment are attributable to “higher infection rates and higher use of public sector services including antenatal care”. (Padarath et al., 2006, p. 95)

10. Methodology

The methodology is described in what follows. A total of five in-depth case studies were sampled and data collected using in-depth qualitative interviewing. The method sought to understand not only the focal phenomenon, namely the effects of prime age adult illness and illness-induced back migration on rural households, but crucially the broader overarching structural context in which it occurs.

Despite the contemporary proliferation of HIV related research, much enquiry relies on cross-sectional research designs that impose substantial challenges in terms of identifying antecedent factors or imputing the effects of household or health-related dynamics. For this reason, longitudinal research designs are invaluable in tracking these changes. Area based demographic and health surveillance systems are particularly well suited to the task. However, for a relatively contained and exploratory study such as the present one, a nuanced qualitative perspective retrospectively reconstructing the antecedent dynamics potentially introduces an equally useful temporal dimension into the inquiry.

A small purposively selected sample, and qualitative design means the current enquiry is orientated at neither statistical representivity nor generalisability. Rather the objective of the research remained to go beyond the relatively well-documented ‘first order’ effects of morbidity and mortality, to explore the complex interplay between illness and the context in which individuals and households are located. The enquiry sought to remain attentive to the differentiated responses, and the interaction between structure and process. This approach had a number of additional advantages. Firstly, the flexibility and sensitivity of the in-depth qualitative approach is suited to the pragmatic and ethical difficulties of conducting research where the focus is a stigmatised illness. Secondly, the research design allowed the research teams to harness their prior knowledge of the context and the context’s dynamics rather than having to understand a novel research context anew. In addition, members of the research team have returned to the research site for several years and were vaguely known in the village.

Having described the rationale for the research design, it is useful to describe sampling and field practice in more detail.

Sampling

The research took individual households as the primary sampling units, and sampled five households identified as having had a prime age (18 – 49 years old) household member who:

- engaged in return migration to a homestead in the village from another locale,
- exhibited morbidity,
- the morbidity was either confirmed to be HIV/AIDS, or alternatively, was strongly consistent with an HIV/AIDS related aetiology.

With regard to the criteria of HIV/AIDS related aetiology, further clarification is needed. The research teams loosely drew on the WHO (2007) HIV guidelines of weight-loss, pulmonary infections, diarrhoea and fever. The research team also remained attentive to accounts of ancillary, plausibly HIV related immunocompromised symptoms such as skin lesions, severe bacterial infections (e.g. pneumonia), shingles, thrush and pulmonary complaints and upper respiratory tract infections. This was in addition to the WHO performance criteria (at clinical stages two to four), of being bedridden for more than 50% of the last month. Furthermore, as approximately a third of HIV patients are co-infected with tuberculosis, the research teams remained alert to reports of pulmonary complaints and tuberculosis symptoms (Corbett et al., 2003).

Although this process of judging of HIV/AIDS illness was somewhat imprecise and impressionistic, the research team chose not use any form of biomedical screening to establish the precise aetiology of current morbidity, nor did it administer ‘verbal autopsy’ instruments to retrospectively adjudicate causes of reported mortality. This level of medical precision was redundant for three reasons. Firstly, the study’s focus was on the social relational and structural factors. It is hypothesised that household level effects of chronic adult ill health, infirmity and incapacity would be similar for HIV/AIDS and many other debilitating chronic ailments. Therefore, in terms of its effects and consequences, it was not important to distinguish, for example, between HIV and similar complaints such as TB. Secondly, in practice, HIV related illness or death could readily be distinguished from descriptions of other, clearly irrelevant common chronic degenerative ailments such as cardiac or cerebrovascular complaints and the (rarer) spectrum of malignant diseases. Thirdly, the task of deciding on the inclusion of cases as HIV/AIDS related was facilitated by several focal case study individuals volunteering this diagnosis, or village health workers or clinic sisters proffering this as likely, on the basis of their professional opinion.

With regards to sampling, the input of the local Community Health Workers (CHW) or village health workers (as they are locally known) was invaluable as they were able to direct the research team to appropriate cases and facilitated research, and reassured research participants of our bona fides. Akintola (2006) suggests it is extremely difficult to access settings marked by the stigma of HIV/AIDS without drawing on the village health workers to negotiate entry.

Fieldwork practice

The research team was able to draw on its previous experience of working in the focal research context. Entry was gained by local gatekeepers, including the local traditional authority. The village health workers were accessed via the local clinic (where they are based), and the clinic sisters were interviewed to get a general sense of health issues within the village. For instance, the duty clinic sister cued the research team to the system of health referrals, the relative absence of men attending the clinic, and the challenges she faced professionally due to high levels of patient non-compliance. The village health workers were individually consulted and in discussion with the research team, cases that met the criteria were sampled. Care was taken to choose from the range of cases described by the village health workers, and avoid them determining which cases were selected. Contact was made with individuals in the identified households and interviews conducted, in several cases with more than one

individual. Voluntary participation was sought from research participants who were assured of their anonymity and interviewed in confidence (i.e. without the village health worker present). Following one to two interviews with household members (including the ill household member, where possible) supplementary interviewees, such as other household members identified as significant recipients or beneficiary households (relative to the focal household), were interviewed. This methodology had firm precedents in previous work done by members of the research team (see Du Toit and Neves, 2006), but also congruent with other HIV-AIDS related work conducted in rural, developing contexts such as that done by Drinkwater (1992) who draws on a simpler 'cluster analysis', which drawing on participatory methods, thereby seeks to capture resources, exchanges and livelihood activities between households.

In terms of the analysis, the interviews with household based informants were broadly orientated to eliciting data on the following four dimensions:

1. Household context, including household form, members, authority and relationships with kin.
2. Livelihoods and social networks; including relationships, inter and intra household resources flows, practices of reciprocal exchange and support, exchange and entitlement, and receipt of social grants.
3. Migratory practices, and migration linked behaviour (such as communication and remittance sending).
4. Impact of illness, including dependency relations and care burdens, the management of stigma and patterns of health seeking behaviour.

Following household interviews, the focal household's designated CHW was interviewed in confidence. The research team was scrupulous not to disclose information related by the household level informants to the CHW or vice versa. This process provided an important measure of validation. In many cases, the narratives coincided, although in one case the village health worker filled an informant's lacunae, in another case an informant readily related that she had tested HIV positive, yet the corresponding village health worker showed no knowledge of her health status. In some cases, the village health workers had long-standing and close relationships with the focal research participants, but in others, they had less sense of the focal households.

The research team followed a methodology previously used in livelihoods related research of interviewing with parallel translation, and then debriefing at the conclusion of each day and writing up field notes. With one or two exceptions (where informants expressed reluctance or audio equipment malfunctioned) all interviews and debriefings were audio recorded in a digital format. The research team consulted informally with the local clinic sister on

several occasions. Although no specific patients were identified, these exchanges proved useful in terms of clarifying treatment protocols and mapping the vernacular somatic expressions that emerged in the course of interviews, to a more conventional biomedical nosology. This is an important point, because local conceptions of the body and illness, invariably mediate experiences of illness and practices of health seeking (Kleinman, 1980). Understanding informants' experience of illness including: vernacular description of ailments, the ontological context of the self, and the often complex amalgams of healing technologies accessed (such as traditional healers, private and state biomedicine), facilitated clearer comprehension of informant's actions and choices.

11. Findings

The case studies are described in what follows. The cases are synthesised from the empirical material, in terms of the four dimensions detailed above. Each case study is followed by a short commentary, which seeks to contextualise, elaborate on, or draw attention to salient aspects of the case study. Each case study seeks to consider the determinants or mediating factors involved in illness and illness induced return migration.

The case studies are ordered into two broad groups, following an important distinction that emerged in the data. The first group discussed consists of Phumile, Noncebuzi and Nozuzugata: rural returnees that are, relatively speaking, peripheral to the households. The second group consists of Kalima and Nothembakazi, individuals that are household heads or central to their household. In the latter case, the informant is effectively the sole household member.

Case 1. Phumile

This interview was initiated with 35-year-old Phumile at his mother's large, comparatively prosperous looking homestead. Guarded by several vicious dogs the compound is the site of several mud brick structures and an incomplete but expensively constructed concrete block and tile roofed house. The interview was conducted on a cold and wet winter day, in the kitchen of a mud brick structure, seated around a glowing wood stove. Gaunt and frail looking, Phumile returned to his mother's house relatively recently, while his sister Thobela ailed and died here a few months earlier. His mother, Magaza, is the nominal household head.

Phumile proved to be an evasive and at times reticent interviewee. His account was augmented by Magaza's explanations, and a subsequent interview with the nomakhaya (village health worker). To aid reader comprehension the household's members are tabulated below.

No.	Who (h/head is the index person)	Age	Location
1	Magaza (h/head)	50s	At homestead
2	Son: Phumile	35	At homestead
3	Daughter: Thobela (Mother of no. 5)	30s	Deceased July 2007
4	Daughter (Mother of no. 10)	28	In Johannesburg
5	Granddaughter (Daughter of no. 3)	3	At homestead
6	Granddaughter (Daughter of no. 9)	14	At homestead
7	Granddaughter (Daughter of no. 9)	10	At homestead
9	Son (Father of 7 & 6)	30	In Johannesburg
10	Granddaughter (Daughter of 4)	1	In Johannesburg

The immediate, resident household members consist of 33-year-old Phumile, his middle-aged mother Magaza and three granddaughters (numbers 5, 6 & 7 above). A number of absent individuals were enumerated as member of the extended household. These included Magaza's 28 year old daughter, who works at a jeweller in Johannesburg (Phumile's half sister), where she is resident with her one year old infant (i.e. Magaza's grandchild). An older son (Phumile's half brother) also lives in Johannesburg and is father to three children. He and his wife are divorced, so his youngest daughter (viz. Magaza's granddaughter) resides with the ex-wife in Johannesburg, while the two older daughters aged ten and fourteen years old are resident at the village homestead. The third and final of Magaza's grandchildren living at the homestead is a three-year-old toddler. She is the daughter of Phumile's recently deceased sister Thobela.

Magaza grew up and married in a distant village, where Phumile and his sister Thobela were born to her first husband. Magaza never worked outside of the village and on remarrying almost three decades ago she moved with her new husband to the current village. Neither she nor her second husband were originally from this village, and there was the suggestion that this move represented a fresh start for their new marriage. Her second husband (Phumile's stepfather) worked as foreman at Gauteng municipality. He returned to the village after being medically boarded in 1993. He died of 'cancer'-like symptoms, in July 2006. Consistent with local practice Magaza mourned her husband for 12 months, her *ezila* (coming out of mourning ceremony) was conducted on 29 July 07. However on the research team's August 2007 visit, she was wearing the black garments and 'doek' (headscarf) of a mourner, because her daughter, Thobela, had died of AIDS a month earlier after returning from

Johannesburg. Thobela's illness effectively stopped the construction of the new house, as Magaza diverted resources to her daughter's medical care (and transport costs to access the care). In addition, Magaza reported that Thobela's death came during the mourning period for her husband; cumulatively she described these two successive bereavements as very stressful. The strains of Thobela's death were further exacerbated by the fact that she was in a materially weak position. She had no funeral plan or insurance, and had not been working long enough to accrue any savings or death benefits. It was Magaza who absorbed the financial costs, and the subsequent care demands of Thobela's young child. Thobela's boyfriend, the father of her child, lives in Johannesburg and is reportedly unknown to the family.

Thobela's older brother Phumile was born in his mother's village. He left school after Standard 7, and migrated to Johannesburg in 1995 where he secured a temporary job at a municipality as a manual labourer. He worked there for seven years, marrying his wife in 1998 and setting up a home in the matrifocal rural locale. Although inconsistent with the cultural precedent of patrilocal residence, his wife's village has several pragmatic advantages over the virilocal site. It is adjacent to a small town, serviced by piped water and electricity, and in close proximity to the supermarket where his wife works. The couple's three children, ranging in age from five to thirteen, all live with their mother.

Phumile returned to the matrilineal village from Johannesburg in 2002. As he was ill and unable to work his annual contract with his municipal employer went un-renewed. On his returning to the village he describes not getting on with his wife, she reportedly 'ill treated' him and they fought continually. Probing the precise nature of this conflict proved difficult, but 'ill treatment' seems to encapsulate an expansive range of complaints, including the failure to accord Phumile the respect and deference that is his patriarch due. The research team's male fieldworkers - perhaps with a little gendered solidarity - readily interpreted Phumile's displacement in terms of the perils of matrilineal residence. Yet Phumile claims never to have thought of this at the time of his marriage. Although ill, Phumile was able to muster the strength to return to Johannesburg at the end of 2005, and stayed with his step-brother for approximately a year. While living with his step-brother Phumile did not require the level of care he currently does, so while everybody else at the house was working Phumile would take himself to the clinic. Yet his health deteriorated further, and unable to secure another job Phumile finally returned to his mother's home in December 2006. He explained that he chose this residency option over his own homestead due to his ongoing conflict with his wife. (The research team's attempts to interview the estranged wife proved unsuccessful).

Magaza reports that prior to this, Phumile had resisted returning to her home. There was the suggestion that Phumile did not get on with his stepfather, hence the stepfather's death months earlier paved the way for his re-entry into the household. It is significant that Magaza is unambiguously viewed as the household head; Phumile is simply an ill son who needs to be looked after (cultural convention would typically see the eldest son designated the household head). Since his return Phumile has continued to be plagued by ill health, and was hospitalised for three days in May 2007. He also reported being frustrated by the fact that he has not managed to get his money (possibly a retirement benefit) from the municipality. He reports that they assure him it has been paid, yet it never appears in his bank account. Conspicuously ill and unemployed, he struck the research team as a frustrated young man biding his time.

Fatigued and with sunken cheeks, Phumile readily explained that his illness is a consequence of the fact that he has been poisoned, which 'has been eating the inside of him up' (fieldworker's explanation). He visited a clinic in a distant village (rather than the local one – a common gambit to avoid AIDS stigma), and obtained medicine from the doctor. However, as the medication proved ineffective he decided to stop taking it and rather consult a sangoma in the village. Phumile readily voiced his option that he thinks it best that he concentrate on a single treatment modality. When questioned on his plans for the future, Phumile did not mention his conspicuously poor health, instead he indicated he wishes to secure a job and reclaim his children. He clarified, with a hint of beseeching to the research team, that he would be willing to do any work, anywhere. Phumile's account gave the impression that his economic marginalisation was of more concern to him than his ill health.

Finally, when Phumile left the room, his mother elaborated that until recently Phumile did not want to see them (his parents), he simply wanted to stay with his own family at the matrifocal village, before going to Johannesburg to stay with his brother, and only then finally returning home. When he was in hospital in May 2007, she insisted that an HIV/AIDS test was conducted and proved negative. She offered to show it to the research team. (We did not take her up on her offer. The discussion around AIDS stigma seemed extremely sensitive in this household, to accept her offer seemed to potentially call her integrity into question).

In a subsequent exchange, as the research team was giving the local clinic sister a lift to town on a Friday afternoon and talking quite generally about HIV in the village. She gestured while passing Magaza's homestead and asserted that Phumile's demonstrates classic HIV symptoms, and that she that she had personally 'begged' him to come to the clinic. His reply to her reportedly was

that he had undergone a test, and was HIV negative. He consistently claims to have become ill via a slow acting poison imbibed several years ago. The nomakhaya, in a separate interview, elaborated that Phumile has been known to publically declare he and his sister were poisoned by their malevolent stepfather. However, she recalled Phumile had a dalliance with a woman who was working as a domestic worker at an adjacent house several years ago. The woman fell pregnant with Phumile's child, and her antenatal tests revealed she was HIV positive. The infant received medication and was born healthy. The mother and child have since returned to the maternal home in Pondoland, the nomakhaya reported, but she has not heard of them since.

The focal household currently subsists on the Magaza disability grant (for the commonly reported ailments of hypertension and arthritis), and a monthly remittance of R800 from her son who works in Johannesburg (and who has two of his daughters at the homestead). When her husband was alive he received a state old age grant and a R500 work pension, but, after his death, Magaza continues to receive R300 from his pension. She replied that they receive no assistance from the village, and that they have no cows or goats, and 39 sheep, she rather nonchalantly enumerated. Despite her desire to appear poor to the research team, this large flock represents moderate wealth by village standards. As does the substantial house being build on the property by her eldest son. It will be occupied by all of them once completed, she vaguely answered, in response to our queries.

Comments

Phumile, the subject of the case study, illustrates elements of return migration in the context of illness. Both he and his sister's case speak to the denialism and stigma attached to HIV/AIDS. There is in his account, a sense of Phumile struggling to find a place. His migration from urban to the rural uxorilocal household, back to his stepbrother's urban household, and finally to his mother's house, conveys a sense at having fallen out of place. It is debatable if, prior to his arrival, he would have been enumerated as a member of the current household at all. In his elusiveness and spatial movement, Phumile appears to be attempting to find a place.

The case study also illustrates the complex negotiating of stigma, including the claim to have been tested and received a negative result. Ancillary inquiry also pointed to the conflictual relationship with his late stepfather, and the attributions of witchcraft and poisoning that Phumile appeals to explain his illness. He has an ambivalent relationship to allopathic medicine; he is

disenchanted with private doctors, and distrustful of locally available primary health care, resulting in his decision to pursue traditional medicine exclusively. His failure to accept his HIV status and present himself as a subject of formal medicine renders him ineligible for both HAART (Highly Active Anti Retro Viral Therapy) (a precondition of which is pre-treatment counselling), and a state disability grant (eligibility for which is medically mediated). Phumile's economic marginality and the fact that he is being supported by his mother is of significance, he understands his marginality in economic terms. Awareness perhaps made all the starker by the differentiation within the household and the fact that his step-siblings are investing considerable amounts in their rural home.

Case 2. Noncebuzi

Noncebuzi is a 32-year-old woman who lives with her 50-year-old mother, her elderly grandmother and her three young children, the eldest of whom is 8 years old. Although young, Noncebuzi reports suffering from 'ipika' (shortage of breath) and her mobility is impaired due to her grossly swollen ankles (indicative of ankle oedema).

Noncebuzi grew up in a neighbouring village. She dropped out of school in standard 7 and initially made mud blocks in the village before migrating to Durban in 1998. Once in Durban she initially stayed with a female cousin in her shack, and worked as a domestic worker for a succession of black families. This was not lucrative employment and the highest monthly sum of R200 she earned was insufficient to remit to her mother in the village. Her mother had by this stage left her father and was living her own mother (Noncebuzi's grandmother). Noncebuzi usually returned to the village every Christmas holiday, while her oldest, eight year old son lived with her mother and maternal grandmother at the present village homestead.

While in Durban Noncebuzi became involved in a relationship with Xolani, and shared a shack. He worked as an informal carpenter (making furniture), and fathered all three of her children. In December 2006, while pregnant with her last child, Xolani was shot and killed in a robbery. To compound matters Noncebuzi was evicted from their residence, a 'backyard shack' built on the property of Xolani's aunt in the township of Umlazi. After Xolani's death, the aunt explained that 'because the person you were staying with died, we don't have space for you anymore' (fieldworkers translation). Pregnant, unemployed and now intermittently ill, Noncebuzi sought to negotiate with a local landlord for accommodation. He substantially discounted the rent on a small one-roomed shack from R200 to R50, which enabled her to remain in Durban for several

weeks until her youngest child was born in February 2007. After being discharged from the hospital, Noncebuzi vacated her rented shack, stayed with her cousin for a few weeks before finally returning to the village. Having lost her partner, sick, and with three children including a newborn there is a clear sense that Noncebuzi had lost her urban foothold. She sought to stay in Durban, to be able to access the superior perinatal medical facilities. (Home births are the norm in the village; the local clinic sister reported delivering a single baby at the clinic in the past 12 months).

Against the backdrop of this back migration, Noncebuzi reports that she first became ill in 2001 suffering from 'ipika' (breathlessness) and asthmatic symptoms (this is the fieldworkers interpretation, rather than a firm diagnosis of asthma). She reports continually coughing, and her feet are severely swollen (with an ankle oedema that is highly indicative of pulmonary oedema, or possibly a cardiac / circulatory complaint). Return visits by the research team saw Noncebuzi and her family complain not just of her breathless, but also her inability to sleep at night amidst her constant coughing (This too is consistent with a pulmonary oedema). Noncebuzi reports that her shortage of breath was more effectively managed in Durban with the medication she obtained from a government clinic. In response to our queries she reported that she did not know what was wrong with her, but recalled that chest X-rays revealed she has a severely damaged lung. Noncebuzi complained bitterly about the ineffectiveness of the medication she had obtained from the local clinic, and thought the unlabelled packet shown to the research team inferior to the medication obtained in KwaZulu-Natal. Noncebuzi explained that she had given a sputum test sample that proved negative, but a second one is to be conducted. (The treatment protocol for persistent TB-like symptoms requires a second test, it was subsequently established). At this point in the interview, Noncebuzi's mother entered the hut with a pail of water balanced on her head and volunteered that when her daughter gave birth to her last child in Durban they would have done a HIV test. As nothing was communicated to Noncebuzi, they reasoned that her daughter is HIV negative - a conclusion the research team politely noted.

Noncebuzi does few chores around the house, as her health is too poor. If she is feeling stronger, she can sometimes wash dishes and clothes, and clean the house. As she has difficulty walking, Noncebuzi is therefore unable to walk to collect cow dung, or fetch wood or water. She and the household currently survive on an erratic remittance and a collection of state social grants, including a single child support grant obtained for one of the children, her mother's disability grant and her grandmother's state old age grant. She anticipates a second child support grant for one of the children will commence next month. She wants to save these two grants for a month or two and use them to travel to

Xolani's grave (elsewhere in the former Transkei). She indicated that her family had initially prohibited her from going to the funeral because she and Xolani were not married, nor had he paid 'damages' for the (then) two children he sired. (Although how she would have accommodated travelling with her poverty, illness and late pregnancy in Durban, is not entirely clear). Her mother and grandmother are reluctant to legitimate the union and only recently consented to her going to pay her respects at Xolani's grave, on condition she returns on the next day.

The most important members of the household's social network are a beneficent neighbour (who is equally poor) and a brother (strictly speaking a male cousin who was raised within the household). The 'brother' is employed in Gauteng, and intermittently sends some remittances. It is at his rural home, elsewhere in the village, where the grandmother used to live when she was alone, prior to the arrival of the current residents. Finally, there are two married daughters in law who very occasionally assist the household with small sums of money or food, yet their support is limited by the fact that they are married into other lineages. When explicitly questioned on Noncebuzi's return, her mother reported Noncebuzi's presence was difficult as they need money, yet nobody in the household is working. She qualified this by indicating that Noncebuzi contributes to domestic tasks such as cooking when she is feeling well enough. She revealed that as the clinic's medicine has proved so ineffective, they were considering abandoning this form of treatment, and relying exclusively on 'traditional medicine' (from an herbalist).

On a separate occasion, in confidence, the village health worker explained that she strongly suspects Noncebuzi has TB, and hence encouraged her to give a second sputum sample. The village health worker complained that Noncebuzi was 'lazy' (but 'non-complaint' may more accurately capture the sentiment). Noncebuzi reportedly does not check her blood pressure, nor manage her swollen ankle condition well at all. Furthermore, Noncebuzi has, reportedly, in the past consulted a private (biomedical) doctor: an effective, if expensive, way of managing the stigma of attending the local clinic. The village health worker explained that even the clinic sister had grown exasperated with Noncebuzi and told her not to bother with Noncebuzi, as she was simply too resistant to be helped. Finally, there was the suggestion proffered by both the village health worker and fieldworker, that Noncebuzi is a member of a particular clan (in common with the resident fieldworker) that is often known to be 'wsaba ukubulawa' (fearful of being bewitched), and therefore disinclined to take medication.

Comments

Noncebuzi is conspicuously ill, probably with a pulmonary complaint such as TB, and possibly with HIV. Her ankle oedema points to a serious yet potentially easily manageable condition, it is indicative of the poor quality of her health and health care. In the case study, rural back migration was driven by a compound sequence of shocks, which undermined her urban livelihood. Already ill, the death of her partner undermined her security of tenure and eroded her urban livelihood and residence. The precipitating event in her back migration was therefore the ‘entitlement failure’ (Sen, 1999) she experienced, rather than her illness *per se*. Her lack of other options drove her back to her mother’s home. In material terms Noncebuzi is peripheral to her household, both in terms of her access to resources (she sent no remittances during her urban employment) and in terms of her current labour capacity.

The complex rationing of entitlement and claims is evident amongst her kin, and is evident in their unwillingness to allow her to visit her late partner’s grave. Finally, the village health worker ascribed ‘laziness’ to Noncebuzi due to her unwillingness to access the clinic, but this resistance is likely to be suspicion of the clinic, the local node of allopathic medicine, a desire to pursue alternative (‘traditional’) treatment modalities, along with the management of stigma.

Case 3. Nozuzugata

Three generations occupy the large household compound of Mambhele, consisting of several, rather dilapidated and poorly maintained structures. On the research team’s first visit, the household members were huddled together around a fire in the smoke filled cooking hut. The loss of an urban remittance with the death of her husband several decades ago, gives the homestead the appearance of having long slipped from agrarian prosperity. Mambhele currently occupies the homestead with eight grandchildren, while her five adult daughters are scattered across the district and the distant urban labour markets of Durban and Gauteng. Mambhele’s second born adult daughter, present at the interview and enumerated as a household member, is 53-year-old Masiwela. Although married, and resident at an adjacent homestead, has long since been abandoned by her husband. Masiwela and her mother’s household are closely interconnected: resources are pooled; meals are jointly prepared and consumed.

The household members are tabulated below. Shared maternity between the eight grandchildren is indicated by the letters (a, b, c, d or e) below; each letter indicates one of Mambhele’s five (living) daughters. Also listed in the table is

Nozuzugata (row 3), Mambhele's recently deceased daughter who died of an AIDS related illness.

No.	Who (h/head is the index person)	Age (2007)	Location
1	Mambhele (household head)	77	Homestead
2	Masiwela (daughter)	53	Homestead
3	Nozuzugata (daughter)	43	Deceased Oct 2006
4	Granddaughter (mother is a)	12	Homestead
5	Grandson (mother is b)	4	Homestead
6	Granddaughter (mother is b)	12	Homestead
7	Grandson (mother is b)	9	Homestead
8	Grandson (mother is c)	16	Homestead
9	Grandson (mother is c)	18	Homestead
10	Granddaughter (mother is c)	4	Homestead
11	Granddaughter (mother is d)	5	Homestead
12	Grandson (mother is e)	3	Homestead

The mothers of the children (listed above as mothers a, b, c, d, or e) are briefly described as follows. Daughter 'a', mother of granddaughter 4 is married and lives a nearby village. She has two younger children born within the marriage, who reside at the nuptial home. Daughter 'b', mother of the grandchildren 5, 6 and 7, lives at a more distant village. Daughter 'c', mother of grandchildren 8, 9 and 10, is in Gauteng where she works as a domestic worker, and sends a monthly remittance to the household. Finally, daughter 'd', mother of granddaughter 11 is in a distant urban area, while daughter 'e' mother of grandson 12, is resident at a distant village. Apart from the small remittance received from one of her daughter's, the household subsists largely on Mambhele's single state old age grant and five child support grants for the grandchildren.

The third born of Masiwela's six daughters was Nozuzugata who constitutes the focus of this case study. She died in October 2006 at the age of 43. Born and raised in the village Nozuzugata's mother and sister were unsure of her educational attainment. She, like her sisters, did not matriculate. She lived in Durban for many years and worked as a domestic worker for a Muslim family. Although she never married, her three children were fathered by the same man, and they all lived in an informal settlement on the outskirts of Durban. (Neither of the two adult informants present were sure where). In approximately 2002-2003 Nozuzugata's partner ailed and eventually died, following which she became ill. It was only in late 2005 that Masiwela visited her sister, and saw she was very ill and losing weight. Nozuzugata was regularly attending the clinic in Durban, but suffered from constant stomach complaints and diarrhoea. Although

she did not tell Masiwela what was wrong, she indicated she was being treated for TB. In addition, Nozuzugata was scrupulous to hide her clinic cards, Masiwela recalled. Masiwela returned with her ill sister to the village, where they took up residence at her mother's house. Once Nozuzugata returned to the village she insisted on going to a more distant clinic (approximately 15 kilometres away), rather than the local one. Masiwela reports that her sister said she was being treated for TB, and pills were dispensed. Yet despite this, Masiwela recalls, her sister's condition did not improve and she continued to suffer from stomach pains, vomiting and diarrhoea.

After remaining in the village for six months, and receiving treatment from the clinic, Nozuzugata insisted on returning to Durban. She was gaunt and visibly ill looking at this stage, the informants recall. When the *quqa* (informal, rural pickup truck taxi) picked Nozuzugata up Masiwela overheard bystanders incredulously gossiping about Nozuzugata travelling in her condition. Nozuzugata's insistence on returning to Durban was a source of consternation and disagreement between Nozuzugata on one hand and her mother and sister on the other. They attempted to deter her from travelling, but she replied 'itikiti likuyena' ('I have my ticket', viz. I am going). Masiwela and her mother remain unsure why Nozuzugata felt the need to travel to Durban with the last of her meagre savings, perhaps they speculated, she had business to attend to there. A subsequent interview with the nomakhaya (village health worker) shed no more light on Nozuzugata's seemingly quixotic return to Durban. The village health worker, in whose catchment area Nozuzugata lived, had little sense of her; she reported that although seriously ill Nozuzugata had generally avoided the local clinic and sought out medical attention elsewhere.

It was another of Mambhele's daughters (viz. Masiwela's sister), resident in Durban, who visited the ailing and unemployed Nozuzugata at her shack. As Nozuzugata's condition further deteriorated, the second sister summoned Masiwela to Durban. The two sisters took Nozuzugata to King Edward hospital in Durban, where for the first time they were told that Nozuzugata had full-blown AIDS. Masiwela recounts that although she had suspected this for some time, it still came as a tremendous shock to hear the feared diagnosis confirmed, it 'stung my ears, and hurt my heart' (fieldworker's translation). The hospital dispensed medication, but did not admit Nozuzugata as an in-patient. Masiwela made arrangements for a private car to return her seriously ill sister to the village on a Sunday. The approximately four-hour journey was undertaken at the substantial expense of R2000, a sum that was borrowed against the household's social grants. Nozuzugata died at the rural homestead on the fourth day after their return from Durban.

Subsequent discussions with the local clinic sister suggested late migration of household members followed by their swift death were relatively common. With little sentimentality she termed these returnees the ‘walking dead’; expressing her exasperation that there was little she could do for them as she ran a primary health care clinic. All she did was dispense ‘referrals [to a district hospital] and Panado’.

The research team probed the decision to bring Nozuzugata back to her rural home. Masiwela explained that the decision was taken in conjunction with her elderly mother and Durban based sister. Despite Nozuzugata’s attempt to hide the extent of her sickness, they could see that she was terminally ill. While in Durban Masiwela reportedly reasoned that ‘uba uyafa makanga feli apha’ (if she is going to die, she must not die here). The reasons for not wishing Nozuzugata to die in Durban are multiple. Masiwela explained that she and her mother still hoped that Nozuzugata would recover from her illness. They explained that in the village she would be surrounded by the ancestors, and sometimes this proximity facilitates the recuperation of urban returnees. There was, however, another reason for repatriating Nozuzugata that the informants were initially reluctant to broach. They reasoned that if she died in Durban they would be compelled to repatriate her corpse to the village. This is an expensive undertaking requiring the hire of a hearse. Moreover Nozuzugata did not have her funeral plan of her own, but residence at her mother’s house would render her eligible for burial under Mambhele’s funeral plan. Nozuzugata’s death would constitute a far larger expense if she were to die in Durban.

Nozuzugata had three children: two boys aged 17 and 10 years, along with a 14-year-old girl. They are all resident with the paternal family, namely their uncle (a younger brother of their father), in another region of the Eastern Cape. Although unmarried, Nozuzugata and the children frequently used to visit the paternal family. As the children are accustomed to their late father’s family it was decided they would stay there. Towards the end of the interview, Mambhele made some generic inquiries of the research team concerning her prospects for ‘fostering’ these grandchildren, and thereby obtaining the foster care grant (at R620 per child in 2007). Nozuzugata was not formally married: the children should by rights be with their maternal family, she pointed out.

Comments

The case study illustrates some of the methodological difficulties reconstructing the trajectory and motivations of its subject (viz. Nozuzugata) post-mortem. For instance, it remains unclear why Nozuzugata returned to Durban, effectively

back migrating to her mother's home twice, before her death. Even her kin seemed unable to account for this, although it was quite possible to access treatment as she was in no condition to work. What the case study does illustrate far more definitively is the potentially contested nature of migration in the context of serious illness and how Nozuzugata sought to manage stigma and resist rural return. The case study also suggests the motives, imbricating both sentimental and materiality, for her kin wishing to have her back in the village. Finally the case study indicates the unusual residence of Nozuzugata's children (born out of wedlock) at the patrilocal residence, and the lurking prospect of the maternal kin claiming these children and the foster grant for which they would be eligible.

Case 4. Nothembakazi

Nothembakazi is a slim, fifty year old woman, who lives by herself in a large but decrepit homestead compound, which contains the ruins of a collapsed rondavel (circular hut). Nothembakazi's social confidence and English language skills marked her from the outset as an informant with an enduring (and favourable) history of urban employment. She proved to be a loquacious and candid informant, readily volunteering her HIV status and narrated her successful efforts to obtain ARV treatment.

Nothembakazi is the mother of four children, all of whom reside in Gauteng. These include two adult sons, and twin daughters (one of whom has a child, while the other is completing grade 11). In terms of her personal history, Nothembakazi was born in a more distant village but moved to the present one as a young child. Her father's early death forced her to drop out of school in standard 6. She was married in 1975 via '*ukuthwala*' (abduction followed by marriage), and describes this as a very unhappy experience. She 'divorced' her husband and moved to Johannesburg in the early 1980s, an act she attributed to the fact that she was an only child and therefore had to support her mother financially. Nothembakazi worked as a domestic worker for various middle class white families (generally regarded the most lucrative of domestic employ) from 1980 to 1994, and then at a formal job at a car wash from 1994 to 2003.

In 2003 she was repeatedly hospitalised in Johannesburg with pneumonia and told she was HIV positive. Intermittently ill she was readmitted to hospital several times. When the car wash where she had worked closed down in 2004, she sought employment as a domestic worker for about a year, before returning ill to the village in 2005. Nothembakazi was encouraged to return by her frail mother. Not only did the ill mother and daughter reason that they could look

after each other, but Nothembakazi was depressed and ‘crying all the time’ (her words) which was upsetting her two daughters who shared her rented Johannesburg inner city flat (‘close to Park Station’). In this time she largely subsisted on the R18000 retrenchment package payout from her job at the car wash. Approximately a year after her return to the village in late 2006, Nothembakazi’s elderly mother died.

Of her children the eldest adult son lives with a friend. The younger of the two adult sons, and the daughter who continues to attend a former model C school, live with their father (Nothembakazi’s ex-husband). While the daughter with a child lives with her boyfriend. Nothembakazi reports that lobola (bridewealth) has not been paid, and the union is not yet formalised. The children’s father, from whom Nothembakazi is divorced, supports the younger children financially. He does not send Nothembakazi any money.

Since her return to the village Nothembakazi tested positive for TB and obtained treatment at the local clinic. She also travelled to the nearest town (about 45 minutes drive on unpaved roads) to consult a private doctor who gave her a referral to a public hospital. She chose not to go to the closest public hospital (in the same town), but rather obtains ARVs from a more distant health facility she perceives to offer superior care. Nothembakazi applied for and obtained a Disability grant from November 2006 to May 2007, her sole source of income after she exhausted the retrenchment payout. In a context where access to formal health services can be difficult, Nothembakazi seemed to be an informed and engaged health system ‘client’: she scrupulously collected her monthly medication, could readily cite her vacillating CD4 count and generally seemed well versed in and motivated to manage her health condition. She further added that she felt ‘called’ (by the ancestors, in a dream) to train as a sangoma in 2006, but found the training too onerous and soon gave this up.

Nothembakazi reports that she intends to reapply for a Disability Grant. She has struggled with no income, and sold off some of her clothes that no longer fit her (‘I used to be nice and fat’, she explained wistfully). In terms of how she survives, she is intermittently given small sums of money (e.g. R20) or food, by her married ‘sister’ (actually a distant cousin), who lives in a nearby village. However the ‘sister’ is herself widowed and struggles with money. She used to help out Nothembakazi with some of her more onerous domestic chores when she was feeling very ill, however this ‘sister’ is torn between this and the demands of looking after her own children and doing domestic ‘piece jobs’, for money within the village.

A significant source of support for Nothembakazi is the nomakhaya (village health worker). Nothembakazi has reportedly told the nomakhaya of her HIV positive status, but has not yet told her daughters, who continue to believe that she is (only) suffering from TB. The relationship between the two women extends beyond carer and patient; they are friends, cousins, clanswomen, and neighbours. The nomakhaya was initially close friends with Nothembakazi's mother and did not know the then Johannesburg resident Nothembakazi well; the two women became close since Nothembakazi's return to the village. The nomakhaya would visit regularly and encouraged the ill Nothembakazi to attend the local clinic. Nothembakazi initially attended a more distant clinic, en route to town, but would then struggle to get a place in a vehicle returning to the village as all the *quqas* (informal rural pickup truck based taxi) would be full of passengers returning from town. When Nothembakazi collapsed at the social grant payout point the nomakhaya arranged transport to take her to a private doctor in town and lent her moral support. The nomakhaya routinely sends a child to give Nothembakazi home-grown vegetables, and reportedly contributed groceries to Nothembakazi's sons when they were being initiated.

When Nothembakazi was asked how she reciprocates the nomakhaya's assistance, she explained that she lent the nomakhaya money when the R500 payment from a small project did not materialise. The nomakhaya needed the full sum to pay into her umgalelo (mutual savings society), as it was close to the end of the year and to miss a payment would mean forfeiting the entire payout. Nothembakazi lent the nomakhaya this sum from her disability grant; and was reimbursed when the nomakhaya received her R1700 payout several weeks later. In this context the nature of entitlement and management of obligation deserves a little more attention. Nothembakazi's eldest, 29 year old son has fathered three children (with different women) in the district. When the (maternal) grandfather of the youngest 3-month-old child, bought the child to Nothembakazi and demanded that she take it, Nothembakazi refused. She replied that her son is not formally employed in Johannesburg, and she is sick and impoverished, therefore she is unable to look after a grandchild. The maternal family relented and retained the child.

Comments

The case study of Nothembakazi reveals a woman who had retreated from a relatively favourable position in the urban economy (formal employment, rented inner city flat, children at former model C schools) in the face of HIV related illness. Her back migration was however motivated by desire to both obtain and dispense care in relation to her elderly mother. Through her own agency, and

close reciprocal relationship with the nomakhaya (in turn built up on the palimpsest of a prior kin mediated relationship) Nothembakazi has proved adept at constituting herself as a ‘HIV positive’ subject of biomedicine. This entails more than simply taking medication: it demands the negotiating of stigma at village and familial level, keeping informed regarding her precise health status (CD4 counts), renewing applications for disability grant, and reconfiguring her identity as an ‘HIV positive’ recipient of treatment. There is a similar suggestion that the negotiation of personal agency is reflected in her failed, ‘ukutwala’ (literally ‘the taking’) marriage. (Although frequently cast as ‘abduction’, there is often a complex negotiation of female agency within the cultural script of this traditional betrothal process). The reported willingness of her ex-husband to materially support the children suggests some of his allegiance to their welfare. Finally the case reveals something of the complex rationing and management of entitlement, in her rejection of her infant grandchild.

Case 5. Kalima

Kalima is a 49-year-old woman who occupies a very modest two-roomed rectangular home along with her two children, a sixteen-year-old daughter and a twelve-year-old son. Kalima has a total of four older daughters. The eldest is married and lives in a regional town (two hours of travel away). Resident with Kalima’s daughter is her older teenage children, who are enrolled for grade 9 at a local school. The fourth of Kalima’s older non-resident children is adult daughter who lives in Johannesburg with her boyfriend and child. The research team never entered Kalima’s modest home, instead she opted to conduct all interviews at the adjacent home of her friend, confidant and allocated village health worker, Sindiswa. The two women were interviewed separately, and in confidence.

Kalima was born in the district, and attained a standard five level schooling. She married her husband, who was six years her senior, in 1975. He was a municipal worker for most of his working life but took a ‘package’ in the early 1990s and returned to the village. (It is unclear if this was early retirement or retrenchment). Around 1996 he had a stroke, and suffered from immobilising paralysis and an inability to speak until his death in 1999. Kalima reports that her husband’s illness consumed their fixed savings, and medical expenditure saw all of his life policies and funeral plans lapse. The extent of their economic decline is evident in the fact that a brother in law had to assist with the funeral expenses. Kalima describes this as a difficult time during which she struggled materially, she survived by making mud bricks in the village (amongst the most drudge intensive of rural self-employment), until she herself grew ill.

Kalima became ill in 2000 with chest complaints, and remained intermittently ill for several years, receiving treatment for TB. Early in 2007 she suffered from ‘a problem with her head’ (fieldworker’s translation). This appeared to have either been a psychological or neurological episode, whereby Kalima displayed a blunted affect, and became withdrawn and impassive. Her short-term memory was impaired, but appears to have returned. (This episode does not appear to have resulted in enduring gross neurological impairment; Kalima appeared lucid to the research team). Her married eldest daughter (resident in the region) took her to a private doctor, who diagnosed her as HIV positive in June 2007. Apparently she was so impassive and confused, that her daughter had to give consent for the test. Kalima is currently in receipt of a state Disability Grant, and describes relying on this sum for her survival. She also gets an injection at the local clinic every day (standard treatment for TB patients who have defaulted on oral medication or suspected multiple drug resistant TB). Kalima ventured that people say HIV can develop from TB, as she has been suffering from pulmonary complaints for some time; this is how she thinks she contracted HIV. She collects pills (they were unlabelled) from the clinic ‘for HIV’. (Yet the research team established ARV’s are not dispensed there).

Kalima is extensively helped by her community health worker, friend and benefactor, Sindiswa. Sindiswa lends Kalima money, gives her food and regularly checks up on her. There is a long-standing relationship between the women, they are neighbours and have known each other since the mid 1970s when they married into their respective households. They are distantly related (Sindiswa’s mother in law shares a clan name with Kalima). Over the course of several decades the two women were bound together through reciprocity; they used to loan each other small amounts of consumables and look after each other’s children when necessary. When asked how she helps Sindiswa, Kalima explained she played a key role in organising the funeral arrangements for Sindiswa’s deceased daughter. When Sindiswa travels outside of the village, Kalima would oversee and cook for her resident grandchildren. Kalima also distantly recalls that she used to collect Sindiswa’s remittance (sent by her then working husband) at the Post Office.

In a subsequent, confidential interview with Sindiswa, some of the elisions in Kalima’s life history were filled. Sindiswa explained that after the death of her husband several years ago, Kalima had a dalliance with a man who had come to the village to tend the livestock of a school teacher (Tending livestock is often the work of retired men or younger boys, it would have been a low status occupation for a working age man). Kalima eventually moved out of her house and with her boyfriend took up residence at the vacant homestead of one of her distant cousins. At this time, Kalima’s children continued to live by themselves

at her house. Sindiswa explained that although Kalima was hardly the first widow to become involved in a new relationship, a widow's boyfriend must come and go 'respectfully'. He must come in the evening and go in the early morning, for one needs to 'respect the house and the children' (fieldworker's translation). Kalima's brazenness, and the fact that her still fairly young children were being neglected, scandalised the village. When Kalima's married adult daughter returned to the village during a periodic visit and found the children 'neglected' (fieldworker translation); she promptly remonstrated to the local Chief about her mother's errant behaviour. Even the local village branch of the ANC Woman's league became drawn into the fray, and demanded to know how Kalima could leave her children unattended.

Kalima's boyfriend had by this stage left his employment herding livestock, and both he and Kalima tried to earn income by making mud bricks within the village. There was little income at this time so nomakhaya Sindiswa resigned herself to looking after the children. While the younger boy slept at her house and the older girl slept at a relative's household, both children regularly ate with Sindiswa's family. Sindiswa recalls that her husband would complain about supporting the children and routinely threatened to chase them back to their mother, although he never did this. After several months Kalima's boyfriend grew ill, and attended the clinic, following which he and Kalima had a heated altercation when she surreptitiously attempted to look at his clinic card. Sindiswa was summoned to mediate their conflict, in which the boyfriend revealed he had been diagnosed HIV positive at the clinic. He deteriorated rapidly thereafter, until Kalima was forced to take him in a wheelbarrow to the home of a bakkie (pickup truck) owner in the village, who drove the terminally ill boyfriend to the home of a policeman in another village (who shared a clan name with the ill man). The policeman in turn returned the man to his own family where he soon died thereafter. This, Sindiswa thought, is how Kalima contacted HIV. Although the women remain close, Sindiswa indicated that Kalima has never explicitly spoken about being HIV positive (yet Kalima spontaneously disclosed this to the research team). Sindiswa explained that Kalima unselfconsciously collects monthly food parcels from the clinic, that everybody knows to be reserved for the AIDS sick. Kalima's seropositivity was something widely known, but left unstated, Sindiswa suggested.

Within this case study, the nature of entitlement is also worth reflecting on in a little more detail. On Kalima's property, behind her modest home, is the half-completed shell of a much larger house. In response to the research team's enquires, it emerged that the structure was being built by her married daughter and son in law (the reproachful daughter resident in a regional town). Kalima seemed unable or reluctant to say who would occupy the house. While she

described herself as poor and ‘suffering’ (her word), her eldest daughter was clearly investing large sums of money in a (matrilocal) rural residence. Kalima suggested that the building activity was delayed by her recent bout of illness that required her daughter pay for expensive visits to the doctor, but ventured that she and the grandchildren would occupy the house on its completion. Sindiswa in turn, explained that construction on the house was halted, as Kalima’s family (primary her married daughter) were angry with her for becoming ill through her sexual indiscretion. Sindiswa concluded by stressing that Kalima is normally a very reliable person, and when she does something (building, childcare, running errands etc) she does it to perfection. The illness, she explained, made Kalima act out of character, but she is now acting like herself, like a mother again, Sindiswa concluded.

Comments

This case suggests a number of interesting points, not least of which is the fact that Kalima’s migration was of a local, micro sort, simply between two homesteads within the village. HIV vulnerability seems not to have been patterned along the contours of long distance, urban migratory networks, but rather intimate, local linkages. This case also reveals aspects pertaining to co-residency, care, treatment, and claims to entitlement. Although it was hardly the objective of the research to trace the aetiology of HIV infections, Kalima’s candour in all but her relationship (after being widowed) is significant and speaks to the working of stigma. Within the village, the primary complaint against Kalima was not the relationship *per se*, but rather the lack of discretion with which it was conducted, and the neglect of the children. Village health worker Sindiswa’s account of this episode, and the scale of the opprobrium it elicited, suggests something of the prevailing mores and norms. The case study also points to the complexity of the relationship between Kalima and Sindiswa, marked by a long history of interdependence and reciprocity, and straddling categories of friendship, kinship, neighbourliness, and health service provider and patient. It also illustrates the complex relationship with her married daughter, and the daughter’s influence in shaping material conditions and back investment at the matrilocal site. The final noteworthy element from this case study is the account of Kalima’s transient boyfriend, his marginality and death speaks of his gendered vulnerability. It is suggestive of the manner in which men often can elude the purview of household research.

12. Discussion

In what follows the case study data is drawn on, and general dynamics and themes elaborated on to consider back migration in the context of HIV/AIDS morbidity and mortality. (These general themes are tabulated in appendix 1). The discussion that follows is developed around the following points. The first is the proposition that there is no singular, generic, illness-induced rural return migration, instead there is a multiplicity of migration. The second theme follows from the first, and suggests illness and migration do not always co-occur. The third theme concerns the differential position and effects of returnees within their receiving households. The fourth theme considers the extent to which return migration is influenced by health seeking behaviours and local care practices, while the fifth theme examines how consideration around death are an important aspect. The sixth and final theme examines, in some detail, how the above illness and illness-induced migration are fundamentally shaped by local social networks.

12.1. Rural return migration is driven by a range of factors

The cases suggest the variety of factors that feed into decisions to back migrate and demonstrate that back migration can take a variety of forms and be driven by a range of determinants and motivations. These are briefly described in what follows. Prominent amongst them is the manner in which illness can undermine an individual's capacity to retain employment and disrupt (usually urban based) entitlements.

In the case of Noncebuzi, she returned to her mother's rural home due to a combination of illness and the dissipation of her urban security of tenure, following the (non-HIV) death of her partner. Similarly, in the case of Nozuzugata, her partner's death preceded her own in illness and rural return. In both these cases illness interfaced with changing urban entitlements, and catalysed rural return. In Nozuzugata's case she was fetched (by her rural kin), whereas Noncebuzi was more clearly pushed by her late partner's urban kin. Similar dynamics of changing urban fortunes are evident in the case of Phumile, who lost urban employment with his deteriorating health. His subsequent trajectory of oscillation between urban and rural sites, saw him displaced from his own rural home, sojourn briefly at his stepbrother's urban home before finally, reluctantly, taking up residency at his mother's homestead. There is, in the case of Phumile, a sense of a young man who is 'looking for a place' in the

formulation of a fieldworker. Phumile also reveals something of the porosity of households; by his own account his mother's house would not have normally been regarded as 'his' home (he had his own uxori-local home, after all). All three of the above cases also convey a sense of the contestation back migration potentially elicits.

In each of the above cases, the specific circumstances of the ill individual interface with shifting affordances, resources, and entitlements to precipitate rural return. The case of Nothembakazi vividly illustrates this, and the extent to which rural return can be driven by factors that extend far beyond the specific circumstances of the individual returnee. She left her urban home not simply because she was ill, but because her distress at her HIV status was upsetting her teenage daughters. In addition her decision to return was motivated not simply to become a recipient of rural care, but so she could care for her increasingly frail mother. In this case a fundamental bi-directional reciprocity of caring underpins her back migration. The reciprocity and interrelation of care work, and the manner in which the ostensive 'subjects' of care themselves exercise agency, has been noted by others (Swartz et al. 2005, Brandt & Bray, 2005).

Even the relatively small number of case studies presented here point to the potential multiplicity of factors driving rural return: the collapse of urban livelihood or residency options (Noncebuzi and Nozuzugata); an exhausting of urban and rural residence options (Phumile); being reluctantly fetched by concerned rural kin (Nozuzugata); a desire to free urban kin of the emotional burden of the illness (Nothembakazi), or even taking up more pressing rural care burdens (Nothembakazi). The plurality of factors that shape return migration suggests it is not attributable to a single homogenous cause or antecedent. As out migration and the decision to migrate are typically underpinned by complex constellations of factors, it is unlikely return migration would be attributable to a single monocausal factor. As the case studies suggest debilitating illness may not even be the most salient of the motivating factors driving return migration. Disentangling migration from illness or narrowly attributing it to the effects of illness remains a conceptually fraught task. Return migration ideally needs to be understood in terms of its interfaces with household level factors, and the insertion of the returnee in the context of both resources, and relationally. These factors are considered in more detail in the final section of the discussion that follows.

12.2. Rural return migration is not co-terminus with illness

This point follows from the preceding one, concerning the plurality of migration. While illness may induce migration, it does not necessarily always do so. Just as return migration routinely takes place in the absence of illness, so too can HIV related illness play itself out at an urban site without rural return migration. This is illustrated by the countervailing case of Kalima, who contracted HIV despite never having left the village. The sole movement recorded in her case is an episode of micro-migration between two homesteads within the proximate area of the village. The manifold pathways of infection are illustrated in the literature by empirical evidence of seropositivity discordance between members of migrant couples (Lurie et al, 2003). Rural return cannot be viewed as the inevitable consequence of illness: migration is simply not co-terminus with illness.

Elevated incidence of HIV induced morbidity may well represent a new motor of back migration, but detailed, qualitative case studies are not methodologically suited to adjudicating the scale of this. Instead what they do reflect is that there are cases of HIV induced morbidity in the absence of return migration, as well as local dynamics that drive vulnerability, along with considerable commonalities and convergences in patterns of rural return migration. To a large extent, the template for these dynamics is set by the precise nature of the relationship between focal rural household and urban locales, considered in what follows.

In conceptualising the relationship between illness and return migration it must be borne in mind that the spatial pathways into and out of households are highly variegated. Migration is patterned by the contours of household linkages between rural and urban sites. It is within these that illness induced return migration takes place. Although return migration is a common response to urban shocks such as illness, it needs to be considered against the backdrop of household structure and the wider spatial networks. In paper one Du Toit & Neves (2006) offer up a schematic four-part typology of households in terms of their urban-rural linkages. Namely:

1. Urban households connected to a rural base
2. Urban households with no connection to a rural base
3. Rural households with a current or recent connection to an urban base
4. Rural households with no current or recent connection to an urban base.

Many returnees to rural sites are part of household types that straddle the rural urban divide, (household types 1 and 3 above). The preponderance of these in

the research is in many respects an artefact of the enquiry, which sought out ill rural returnees. Households that have largely made the urban transition, and have little or no connection to a rural locale (viz. type 2 households above), per definition are less likely to provide examples of rural back migration, or even be included in a sample in a rural based inquiry. Conversely, the final variety of household, rural households with no current or recent connection to an urban base (type 4, above), would be relatively unlikely to incorporate ill urban returnees. It would not have urban-based household members potentially able to exercise this entitlement.

12.3. Return migration has differential effects on receiving rural households

In light of the fact that the determinants of migration vary as do the composition of households, practices and consequences of back migration are unlikely to be homogenous across households, or even the limited number of case studies presented. Illness and illness-induced migration have differential effects on various kinds of households. Although a household member's position within the household is mediated by the familiar social stratifies of age, gender, lineage, in considering the differential impact of illness on the household it is useful to make a distinction between peripheral and core members. Core members are here defined as those who are central to the continuation of the household – their incapacity or death can potentially precipitate collapse of the household. They are typically sources of material resources and typically exercise substantial power and authority within the domestic context. Peripheral members on the other hand, are here defined as those who are less central to the survival of the household. This is neither to suggest that they are unimportant, nor that the erosion of their ability to contribute to the household would not constitute a household level shock. It is rather to argue that the illness or death of peripheral members would not imperil the continuation of the household, or force a radical reconstitution thereof. Therefore while the binary distinction, of peripheral versus core is rather schematic, it does help to differentiate the position various members assume within a household.

Noncebuzi, Phumile and the late Nozuzugata all represent relatively peripheral members of their respective households in terms of both their material contribution to the domestic economy, and the authority they command within it. None of these three individuals sent remittances to the household during their urban employ. Nor does the prospect of their demise threaten the continuation or material basis of the household.

These three cases can be counter-posed with those of Nothembakazi and Kalima, both of whom represent core members, relative to their respective households. In the case of Nothembakazi her rural return is a key act to ensure the perpetuation of the household, with the subsequent death of her elderly mother. As Nothembakazi's children are not co-resident, commensally linked or even identified as household members, she has become the sum total of her single person household. A close alliance with the nomakhaya prevents Nothembakazi from becoming completely atomised, yet the two women continue to be members of distinct households. Hypothetically, if Nothembakazi were to pass away, her household would be likely to dissolve and become nothing more than a collection of unoccupied buildings, or perhaps it would be taken over by a distant family member. Kalima's case study in turn reveals that she shares her household with two dependents; she too is central to her household. A thought experiment anticipating what would become of the household after her death leads one to speculate that her two teenage children would be absorbed into another household (possibly her daughter's or Sindiswa's household). As she is a core household member, her demise would be likely to precipitate radically altered residency and household patterns.

12.4. Rural return is shaped by health seeking behaviours and local care practices.

Rural back migration is shaped not only by practices of household formation and composition, but also by health seeking behaviour and care practices. Understanding migration in the context of debilitating terminal illness requires attention to these dimensions of health seeking behaviours.

The case studies suggest the multiplicity of treatment modalities ill returnees engaged with, for example Noncebuzi and Phumile rebuff allopathic medicine from the local clinic, and instead express a preference for 'traditional' healing. Yet engagement with the various treatment modalities is not necessarily exclusive. Nothembakazi, a generally compliant subject of biomedicine feels herself briefly 'called' by the ancestors to become a traditional healer 'sangoma', but soon abandons the calling. Noncebuzi and Phumile, both consulted private medical practitioners before resolving to pursuing treatment in the realm of traditional medicine. This sequence of engagement with disparate treatment modalities may be partly explicable in terms of their desire to avoid the local clinic (the local public health system gateway), due to the workings of stigma. Padarath et al observe, "There also appears to be a reluctance among people to use services where local community members are employed for fear that the confidentiality of their status would be compromised" (2006, p. 98). In

addition the search for treatment can be motivated by other desired outcomes. For example the narrative of now deceased Nozuzugata's return to the village, suggests the expansiveness of her health seeking behaviour, motivated as it was by the twin objectives to obtaining succour through the strength of the local ancestors (in her mother's explanation), and care from her own kin.

Finally, sustained health seeking can also be intertwined with aspects of subjectivity and personal agency. Phumile allies himself to 'Xhosa herbs' and stoic masculinity, and he is reluctant to engage with village level health infrastructure, or the researchers for that matter. Tellingly, his foremost concern is less his ill health than his inability to earn an income, in accordance with the cultural script of the male provisory role. Phumile's rejection of medicine can be instructively contrasted with the case of Nothembakazi who successfully engaged with the biomedicine establishment both prior to and since her rural return. She consulted a private medical doctor, obtained a referral and sought out a regional hospital dispensing ARVs (on the basis of its reputedly better quality of care). She reports taking her medication scrupulously and her ability to recite her vacillating CD4 count suggests a patient with keen knowledgeable about her condition and motivation to manage it. Moreover Nothembakazi with her loquaciousness and candour in relation to unfamiliar researchers (perhaps in anticipation of resources) displays an openness that might be contrasted with reticent Phumile. The case of Nothembakazi recalls the notion of 'health citizenship': forms of illness or biological-based identity that combine social activism and shared experiences of extreme illness and stigmatisation (Robins, 2004; Robins 2005). Although she displayed little overt social activism, there was a clear sense of how Nothembakazi had reconstituted her identity by drawing heavily on a rubric of personal empowerment, the confessional ethic of HIV status disclosure, and diligent engagement with 'pharmacological salvation' (Comaroff, 2005 in Robins, 2005).

Health seeking behaviours and identities are also intertwined with local care relationships. Nothembakazi, a patient subject of biomedicine, is supported by her close relationship with the village health worker. Phumile and Noncebuzi, having largely eschewed local clinic services, are resistant to the ministrations of the village health workers, and the overtures of the larger village level health machinery (such as the clinic sister who futilely 'begged' Phumile to come to the clinic). They are consequently cared for by their kin. These different routes to obtaining care are partially explicable in terms of stigma, but also invoke beliefs about the body, health, proper social relations and entitlements, and even broader ontological concerns. For instance primary health care staff readily attributed the reluctance of many patients to giving sputum samples or taking medication to their fear of being bewitched.

12.5. Rural return migration is mediated by understandings and practices of death

Finally chronic, terminal illness is shaped by considerations of mortality. With only about 40% of African deaths occurring in hospital, Uys (cited in Akintola, 2006) discerns a clear preference for kin to die at home rather than at health facilities. Two of the case studies saw return migration, followed swiftly by death. A local clinic sister, noting the relatively late back migration of many terminally ill patients, called them (somewhat uncharitably) the ‘walking dead’. Padarath et al (2006) suggest, “Disclosure of status is often linked to advance stages of HIV-related illness, with some people disclosing their status just before death” (p. 97). The reasons for relatively late back migration of terminally ill returnees is unclear and difficult to discern from the existing research, it may reflect the availability of superior urban health resources, shifting patterns of urban entitlement, a desire to die with rural kin or, most likely, a combination of these. An important methodological aside is that in light of very late return migration it is difficult knowing where people will choose to die, until they do. Hence evidence of terminally ill rural migrants remaining at urban sites cannot be viewed as conclusive proof of a preference for urban residence because they may be engaged in rural return migration just prior to their deaths.

In the context of terminal illness, rural return is not just underpinned by local idioms of death and dying, it can be rooted in more pragmatic concerns. These are arguably comparable to the concerns over effectiveness, accessibility, identity-congruence, and confidentiality that drive health-seeking behaviour. Recall the case study of the late Nozuzugata; she died four days after her escorted (re)return to the village. This enabled her to be buried under her mother’s burial policy, thereby freeing Nozuzugata’s impoverished kin of the expense of repatriating her mortal remains from Durban. Similar migratory practices are noted in East Africa where “One is to send sick relatives from the city back home to die since a bus or train ticket is far cheaper than transporting a corpse...” (Dilger, 2006, p. 115). Therefore, despite the denial that often surrounds serious illness and the prospect of death, complex patterns of obtaining local succour, local care and controlling the often considerable costs of local burial, are evident.

12.6. The management of stigma is an important dimension of rural return.

The case studies suggest that the management of stigma is an important dimension of rural return. In her interview Kalima omitted mention of her boyfriend who subsequently died of AIDS, but rather hypothesised her HIV infection had evolved from TB. Phumile negotiated stigma by claiming to have had an HIV test that he claimed was negative; instead he attributes his illness to witchcraft. Phumile's late sister denied her HIV status and kept it secret from her family. Nozuzugata visited a more distant clinic, to maintain the secret of her HIV status. A related tactic to prevent disclosure and avoid stigma, is the hiding of clinic cards (Nozuzugata and Kalima's late boyfriend did this). Clearly the negotiating of the stigma associated with HIV influenced much behaviour. It may well shape decisions to return and, conversely, account for some of the reluctance to return on the part of several of the respondents. Particularly as stigma and its dimensions of labelling, blaming and shame, and silence and secrecy are believed to be more pronounced in rural areas (Duffy, 2005).

As the management of stigma is an important component of illness included return migration, the precise nature of stigma deserves further consideration. The association of HIV with sexuality is conventionally understood to be the driving motor of stigma. However this intuitive connection of stigma with sexuality offers limited explanatory value. Although socially conservative, traditional African society has generally been relatively tolerant of sexuality, with polygamy practiced and extramarital or premarital pregnancies legitimated through recompensatory rituals. Although shaped by the conservatism of Christian missionary mortality, sexuality in present-day sub-Saharan Africa arguably incurs less moral censure than in many other parts of the world. Delius and Glasser (2005) hence suggest HIV/AIDS stigma to be less about sexual shame and more readily explicable in terms of "concepts of pollution, belief in witchcraft and popular understandings of contagion" (2005, 29). HIV/AIDS therefore invokes expansive registers of defilement and pollution. In addition the secrecy surrounding HIV, and an asymptomatic period followed by (when unmedicated) terminal decline which mimics the effects of poisoning, and lends HIV/AIDS a ready association with witchcraft (Ashforth, 2002).

The fear of 'symbolic contagion' associated with HIV/AIDS that drives stigma also articulates with pre-existing social hierarchies and divisions. The demonisation of women in relation to AIDS stigma has been described by several commentators (Ashforth, 2002; Gaitskell, 1982; Campbell, Foulis, Maimane, & Sibiya; 2005), along with the 'systems justifying' function of

stigma (Campbell et al. 2005). For example in the case studies, Kalima is (retrospectively) blamed for becoming infected; this and the considerable moral opprobrium her dalliance elicited suggests the nature of local social ‘policing’ of sexual mores. Note, too, the place of social propriety: it was not the fact that widowed Kalima was involved in a relationship; rather that she conducted it without suitable decorum and discretion. It did not ‘respect the house’, in a fieldworker’s translation.

12.7. Social networks in the context of illness and illness induced back migration

While the dimensions of illness-induced return have been considered in some detail, this concluding section considers these in relation to social relationships. It considers the primacy of social networks, and their role in shaping back migration and domestic arrangements.

12.7.1. Social networks are animated by complex, multifactoral care practices

Social networks are animated by complex patterns, systems and ethics of care. Much of the burden for the care of ill returnees falls to existing household and kin members. This was evident in several cases (Phumile, Nozuzugata and Noncebuzi). Whereas Kalima and Nothembakazi (and perhaps Noncebuzi to some extent), are cases where the village health worker assumes responsibility for the burden of care. Due to the use of the relational infrastructure of village health workers to facilitate the identification and accessing of case studies in the research project, it is unsurprising they are prominent in accounts as significant sources of support for ill household members. Their precise role and relationship to several different ethics of care are considered in more detail below.

The first point is that HIV/AIDS care, and care work in general, often entails elaborate amalgams of individual action, social practice and forms of ‘occupation’. This work entails a horizontal philanthropy of positive interpersonal and communal values (or ‘ubuntu’ in more Africanist register). However, care work, particularly when mobilised in more systematic ways, offers its practitioners the promise of a little income, external resources, or even favourable positioning within circuits of local patronage. It can therefore be a significant route to the accrual of local influence and social respectability. Chazan (2006) accordingly suggests that AIDS caregivers:

“are driven by a myriad of complex factors: being personally affected (being HIV positive, experiencing a bout of acute or near-death illness, having a family member who is living with HIV, or suffering with personal loss); out of caring for the community; as a livelihood strategy (or hope of future funding or employment); for education and training opportunities; for information and support; for religious reasons or out of a sense of shared destiny; out of feelings of duty or responsibility; and to resist discrimination. Many participants expressed the formation of collective identities within their groups, both around ‘being positive’ and around counteracting the psychosocial impacts of unemployment” (p. 26).

Care work is therefore a complex activity that embraces ideologies of communitarianism, shared destiny and identity along with personal benefit.

The multiplicity of the motivations underpinning communitarian activities such as care work, or various community development initiatives have been noted by others. For instance Bank (2002) describes the adeptness with which specifically rural women have become adept at positioning themselves as participants in a long succession of community development projects in the rural Eastern Cape. Their success as ‘developmental entrepreneurs’ is partially a result of the success women have in harnessing and transacting within networks of gendered solidarity. A small caveat at this point: these observations are not to decry the communitarian ethic that often drives participation in these interventions, simply to note the tidy social reciprocities that can underpin it. For ultimately the moral and social imperatives of caring for the sick and generating income are not readily separable from the identities and practices of everyday life. A final point in thinking about the practice of care work, and the register of voluntarism on which it is partially predicated is that one ought to be cautious of valorising the manner in which much of the burden of social reproduction in the face of HIV/AIDS has been displaced onto the shoulders of the impoverished, rural residents, and women (Marais, 2005; Hunter, 2007).

The complex and the multifaceted nature of care and dependency relationships is further evident in the way in which the village health workers, in their relationship with households or ill household members, can straddle several varieties of social connectedness. At one level these are relationships constituted by biomedical modernity: that between auxiliary medical service provider and patient. Yet case studies such as Kalima and Nothembakazi reveal long-standing relationships between CHW and household members, relationships are often built up on forms of social connectedness such as neighbourliness, clan identity, or the palimpsest of kinship. Therefore, while the social and occupational status of the CHW is constituted by formal medicine, they often transact within

kinship or affinal based networks. In addition many of these kin relationships are multi-generational and longstanding, such as the relationship between Nothembakazi's late mother and the specific CHW described in this case. They are also marked by the reciprocity and mutuality of support that normally characterises social relationships (such as Nothembakazi loaning money to the family-friend nomakhaya; Kalima's history of childcare for nomakhaya Sindiswa)

12.7.2 Rural return can be marked by conflict and contestation

The case studies illustrate the conflict and contestation potentially attendant to the return of an ill household member. In his displacement from the uxori-local residence and eventual move into his mother's homestead, Phumile's migration was marked by conflict and conveys a sense of his marginalisation. Noncebuzi's kin prohibited her attending the funeral of her late partner, as compensation had not been paid for the three children, a point of lingering contention. The prohibition on her attendance at the funeral reflects her relative disempowerment in two intertwined domains: she is both economically vulnerable (with no resources of her own), and socially marginal (her relationship with her late partner enjoyed no formal sanction and is unrecognised in customary terms). In the case of late Nozuzugata she effectively returned to her rural home twice. To the consternation and contrary wishes of her kin, she engaged in an urban recidivism and returned to Durban. Following which she ailed further and was returned to the rural homestead by her sister, to die days later.

Much of the conflict and contestation that marks return is explicable in terms of the social calculus of obligation, entitlement and the rationing of entitlement. For example Noncebuzi's entitlement to attend the funeral of her boyfriend was actively rationed by her kin. Similarly Nothembakazi resists taking in the grandchildren fathered by her son, they need to reside with the maternal kin she insists, as she is ill and bereft of resources. This social contestation points to the frequently enforced characteristic of social entitlement. The conflict and contestation that marks return is not always readily distinguishable from the workings of stigma, for example, although witchcraft speaks to the ontological insecurity of Phumile, it is a well-worn idiom in which conflictual interpersonal relations are cast (Delius, 1997). Moreover, mutual claims of witchcraft, van der Waal observes (1996), frequently accompany the dissolution of marriages.

12.7.3. Social networks incorporate their ill subjects in differentiated ways

The social networks into which ill household members enter are unequal and incorporate ill returnees in highly differentiated ways. A significant axis of differentiation is gender. With regards to the village health worker infrastructure, men are generally less in the purview of the primary health care system and the ministrations of the CHW than women are. In the focal research context the clinic sisters reported the overwhelming majority of patients are women and their children, whereas men proved elusive. Women are also more likely to know their HIV status as they are routinely tested for it as part of antenatal care. The enforced amenability of the female body to the biomedical gaze recalls Bordieu's notion (1977) of the body as socially formed, and culturally constructed (Fassin, 2002). In fact the face of primary health care at village level seems extremely feminised, extending from the patients to the village health workers and the female clinic nurses themselves.

Gendered asymmetries are equally evident in the dispensing of domestic care work. Men proved absent from these within the small selection of case studies, yet this is part of a general absence, noted by others (Denis & Ntsimane 2006, Desmond & Desmond, 2006, Hunter, 2006). In fact, when considering the few men analytically captured in the study, there is a sense of their invisibility from the domestic realm. In Phumile there was a palpable sense of his frustration related to his unemployment and economic marginalisation, and his desire to escape from his recuperation at this mothers homestead. This liminality and vulnerability of men is graphically illustrated by the case of Kalima's boyfriend. Terminally ill and in an unformalised relationship outside of his own village, he slips out of networks of care, he is returned in a wheelbarrow (and via several sets of clan-affiliated intermediaries) to his familial homestead, where he soon dies thereafter

13. Conclusion

This paper examined the impact of HIV-induced illness on return migration in a specific rural context. It sought to understand the phenomenon within the context of limited opportunities for effective treatment, existing practices of population mobility and prevailing affordances for livelihood making. The paper showed that, although debilitating, chronic illness such as HIV/AIDS may be associated with rural return migration, even the relatively small number of case studies presented point to the plurality of individual motives and household

strategies underpinning return migration. Far from homogenous or amenable to easy generalisation, illness-induced rural return migration interacts with various characteristics particular to both the returnee and the receiving household.

The case studies revealed the diverse and even divergent places returnees can occupy within their households. In some cases they are relatively peripheral, so that their morbidity and mortality does not seriously imperil the material basis of the household; in other cases returnees are the crucial to the household, and their demise comes to threaten its continuation. The paper also sought to consider how rural return is motivated by elaborate and often complex practices of health seeking, in some cases it invokes considerations around the management of death and dying, it entails the negotiation of social stigma, and often the demand of claiming resources in order to constitute a livelihood. The paper concluded by carefully considering the social relationships within the context of the household, and suggested that these are animated by diverse practices of caregiving; they are potentially marked by contestation and an enforced quality, and are invariably embedded in an intimate politics of care and entitlement, within spatially extended networks of social exchange and reciprocity.

Appendix 1.

Case Study summary table

<i>Case study (listed by name of focal individual returnee)</i>	<i>Focal individuals role in the household</i>	<i>Level of personal agency returnee appears to exercise</i>	<i>Other residency options for focal returnee?</i>	<i>Partner of returnee</i>	<i>Fate of focal returnee's children other dependents</i>	<i>Health seeking behaviour focal returnee engaged in.</i>
<i>1 Phumile</i>	<i>Peripheral</i>	<i>Medium</i>	<i>Exhausted</i>	<i>Estranged from working wife</i>	<i>Yes, with mother</i>	<i>Formerly biomedical, now traditional</i>
<i>2 Noncebuzi</i>	<i>Peripheral</i>	<i>Low</i>	<i>Pushed out</i>	<i>Partner died (not AIDS)</i>	<i>Yes, present.</i>	<i>Formerly biomedical, now traditional</i>
<i>3 Nozuzugata</i>	<i>Peripheral</i>	<i>Low</i>	<i>Pushed out</i>	<i>Partner died (prob. AIDS).</i>	<i>Yes with paternal family</i>	<i>Return to Durban = Biomedical</i>
<i>4 Nothembakazi</i>	<i>Central</i>	<i>High</i>	<i>Pulled back, to look after mother.</i>	<i>None disclosed.</i>	<i>Older, looked after by ex-husband</i>	<i>Biomedical. Compliant & motivated 'patient'.</i>
<i>5 Kalima</i>	<i>Central</i>	<i>High</i>	<i>Not applicable, always locally resident</i>	<i>Husband died. Boyfriend AIDS death.</i>	<i>Yes, present</i>	<i>Biomedical.</i>

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