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**The consequences of  
AIDS related illness and  
death on households in  
the Eastern Cape.**

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## Abstract

*This paper examines the consequences of HIV/AIDS related morbidity and mortality on rural households in South Africa's Eastern Cape region. The literature suggests a range of both individual and household level factors that serve to differentiate the effects of AIDS illness and death on affected households. Furthermore, the effects of HIV/AIDS are not only differentiated, they are also distributed. The social reciprocity undergirding African livelihoods both ameliorates HIV/AIDS-related livelihood shock and simultaneously serves to transmit these shocks to otherwise unaffected households. The six case studies presented demonstrate the highly differentiated consequences of HIV illness and death on households, and the extent to which these effects are significantly mediated by a range of household level factors. The consequences of HIV/AIDS are shaped by household pre-illness asset levels, care and dependency burdens and finally, the extent to which the household members either acknowledge the illness (enabling them to better engage with treatment options) or alternatively, revert to denial. The consequences of HIV/AIDS are also significantly mediated by infected individuals' household headship status and resources. In the rural Eastern Cape, the structural context of unemployment, limited prospects for agrarian production and the exclusion of prime age adults from social grants, serves to pattern vulnerability by rendering unemployed, prime-age adults relatively weak economic agents. The empirical material accordingly suggests the effects of the morbidity and mortality particularly of peripheral (i.e. non-household head) and non-resource contributing individuals is relatively limited (at least in the short to medium term). Within a structural context of impoverishment and economic disempowerment, HIV/AIDS therefore does not constitute a homogenous shock to all affected households.*

# Introduction

This is the third in a sequence of three papers examining HIV/AIDS in a rural African context. The first of the three papers describes the focal research context of the rural Eastern Cape in detail, and considers the dynamics of household formation and composition. The second paper examines HIV induced rural return migration within this context. The current, and third, paper seeks to examine the *ex ante* consequences of HIV related morbidity and mortality, within rural households. These three papers therefore constitute a logical sequence, and ought to be viewed as a series of interlinked texts.

The first paper, *The dynamics of household formation and composition in the rural Eastern Cape* (Neves & Du Toit, 2008), introduced the notion of three levels of analysis by which the problematic of each study could be understood.

These levels are; firstly, the overarching macro-structural context; secondly, the intermediate level social and household context; and thirdly the realm of individual agency and decision-making. This analytic schema was deployed across each of the three papers. In the second paper, *The impact of illness and death on migration back to the Eastern Cape* (Neves, 2008), the focus was on how rural return migration is attenuated by illness, and the prospect of death. Attention was devoted to aspects of individual decision-making and agency. The present, third paper examines the *ex ante* consequences of HIV, and intermediate level household responses to the effects of morbidity and mortality.

The paper is structured as follows: it commences by reviewing the literature concerning the effects of HIV/AIDS on the livelihoods of rural African households. Following which it is suggested these effects are both distributed and socially differentiated between households. The social reciprocity that undergirds rural livelihoods is briefly recapitulated in the paper, as are the dynamics of decision making, before the methodology of the study is sketched, and several case studies are presented. In the concluding section of this paper the array of factors that serve to mediate the effects of HIV/AIDS related morbidity and mortality are described. This concluding discussion does not seek to simply enumerate the consequences of HIV/AIDS on the sample of households examined, instead it discusses these in thematic terms, and reflects on the dimensions along which the *ex ante* effects of HIV/AIDS are influenced.

Robust debate concerning the key drivers of the HIV/AIDS has taken place for much of the history of the epidemic. With the epidemic a quarter of a century old, and having matured and plateaued in East and Central Africa, a diverse

literature reflects on the consequences of HIV in Africa. In the current paper, the concern is with the 'downstream' consequences of HIV/AIDS illness and death. The demographic compositional changes wrought by the epidemic constitute intermediate level effects between the immediate mortality impact of HIV and these 'downstream' social and economic effects (Heuveline, 2004). Accordingly, this paper seeks to understand how HIV is intertwined with the contexts in which it occurs, and the effects of HIV/AIDS are therefore understood in relation to a rural context with high levels of population mobility, fluid and complex practices of household making, described in the preceding papers (Neves & Du Toit, 2008; Neves 2008). Rather than viewing the epidemic as additive, and somehow superimposed onto existing household and demographic dynamics it is understood as fundamentally constitutive. In considering these, it is useful to reflect diachronically on both antecedent events and the cycle of domestic reproduction and household formation. In other words, in the analysis presented there is an attempt to locate the case studies presented in prior individual and household histories, as well as considering their prospective, future trajectories.

## **The effects of HIV/AIDS and rural livelihoods in Africa**

The research context of the rural Eastern Cape was described in the previous two papers (Neves & Du Toit, 2008; Neves 2008). Long incorporated on highly unfavourable terms into the broader political economy of South Africa, the region continues to bear the imprint of underdevelopment. Intended above all as a zone for surplus labour, opportunities for primary agricultural production were poor and declined throughout the twentieth century. The preceding papers also drew attention to how contemporary economic processes have reshaped rural livelihoods across Africa, including in the focal Eastern Cape region (Bank & Minkley, 2005; Bryceson, 1996). These forces have not only reconfigured the prospects for smallholder agrarian production, but also the identities and social relationships that flow from it. Simultaneously rural but with a marginal agrarian base, livelihoods in the rural Eastern Cape have long since been constituted through oscillatory urban labour migration. Initially the preserve of men, migration in the post-apartheid period has become increasingly informal, feminised and uncertain. The second paper (Neves, 2008) considered the pervasiveness of migration, and manner in which HIV/AIDS-induced rural return interfaces with prevailing migratory dynamics.

Against the backdrop of changing livelihoods in the South African countryside, it is useful to reflect in more detail on the consequences of HIV/AIDS on rural households. The experience elsewhere on the continent reveals that HIV/AIDS fundamentally affects agrarian livelihoods (Topouzis & Du Guerny, 1999). HIV/AIDS affected households are likely to substitute crops with less labour intensive but often less nutritious varieties (such as Cassava); scale back cash crop cultivation; decrease their total acreage under cultivation and reduce livestock numbers (Topouzis & du Guerny, 1999; Haddad & Gillespie, 2002; UNAIDS, 2000). The morbidity and mortality associated with HIV can have significant deleterious effects on the food security of affected households. In the face of HIV/AIDS, African households have responded by engaging in casual labour or petty trading (Tibaijuka, 1997), working longer hours, resorting to child labour and reconfiguring (engaging in or withdrawing from) co-operative labour arrangements (Rugalema, 2000). Incomes in affected households may be crowded out by the medical and funeral costs attendant to HIV/AIDS and declining agrarian production variously met with efforts to smooth consumption (by eating lower quantities or qualities of food) or decreasing household size (through out migration or fostering out of children). Declining income potentially elicits efforts to decreased consumption such as, withdrawing children from school (particularly girls), selling off assets (Desmond, Michael, & Gow; 2000), begging, forgoing essential services (such as medical attention), incurring debit and even engaging in out migration (Barnett & Whiteside, 2002; Rugalema, 2000).

Despite the fact that South Africa has the continent's most advanced industrial economy, and agrarian production makes a comparatively limited contribution to rural livelihoods, the effects of HIV on rural livelihoods are still marked. While agricultural production is very seldom the sole source of livelihood for households in South Africa's former homelands, it often crucially augments household subsistence. The consequences of HIV are therefore felt within the marginal land based livelihoods that are crucial for survival. These effects reverberate across the interconnected domains of agricultural production, household food security, rural livelihoods and household composition quite generally. It threatens livelihoods by undermining the ability of infected individuals to engage in productive and domestic reproductive tasks, and imposes substantial care burdens through the long periods of illness which draw other members (often female kin) away from productive tasks (Bicego, Rutstein & Johnson, 2003). This is quite apart from the direct mortality of caregivers themselves. In addition, the effects of HIV/AIDS on urban employment disrupt the remittances and rural back investment, on which much agrarian activity relies (Dovie, Witkowski & Shackleton, 2005). In this way, prime age adult

incapacity and death, serves to exact heavy losses on the material basis of rural households.

Examining the adverse consequences of HIV/AIDS on rural African livelihoods and food security, De Waal and Whiteside (2003), propose the notion of HIV/AIDS as 'New Variant famine' (NVF). They catalogued four factors associated with the epidemic, namely: household level labour shortages and rising household dependency ratios; the loss of assets and skills crucial to successful crop production and animal husbandry; elevated care burdens; and finally, the 'vicious interactions' between malnutrition and HIV (De Waal & Whiteside, 2003, 1234). Although this formulation has been subject to question (see Itano, 2003, Jayne et al., 2005), it helpfully draws attention to the temporal dimensions of the changes in rural livelihoods and the manner in which the 'long wave' (Barnett & Blaikie, 1992) effects of HIV/AIDS render the epidemic qualitatively different from other shocks. This multidimensionality and irreversibility render HIV non-conducive to speedy or early recovery.

The epidemic's effect on land based livelihood are not only limited to the cultivated crops and animal husbandry that fall within the easy purview of research. Land based resources (such natural building materials, comestibles and medicinal plants) are often crucial to rural livelihoods, and can constitute significant 'shock absorbers' under adverse conditions (Shackleton, Shackleton & Cousins, 2000). Adams, Cousins & Manona (2000) suggest land based livelihoods can add a significant quantity of resources to the average rural household's annual consumption (estimated at an aggregate one billion US Dollars in South Africa in 1999). The effects of HIV extend beyond declines on cultivation and animal husbandry, and impact on foraging activities and the accessing of land based resources. This 'natural capital', crucial to many rural livelihoods, is significantly undermined by the effects of the epidemic (Hunter Twine, Patterson, 2007).

Changing patterns of agrarian production and land use serve to precipitate changes in the social arrangements that facilitate access to land, particularly in a region characterised by various communal property systems. Examining land use in the context of HIV/AIDS across several sub-Saharan Africa states, Drimie (2003) notes how the institutional architecture of land administration systems, inheritance practices and property regimes have come under pressure throughout the region. Fields lie fallow due to labour shortages and security of tenure potentially comes under threat (Drimie, 2003; Kamusiime, Obaikol & Rugadya, 2004; Rugalema, 1999). The erosion of assets diminishes the ability of communities to collectively manage resources such as common property rangelands (Haddad & Gillespie, 2002). Moreover, changes in the institutional

dimensions of land access frequently occur to the detriment of vulnerable groups such as woman and children (Bonnard, 2002). A Zambia study estimates that a third of widows lose access to land within two years of their husband's death (Chapoto, Jayne & Mason, 2007). In this way HIV/AIDS serves to erode the institutional arrangements that enabled land tenure in the past (UNAIDS, 2003).

A final consideration in examining the consequences of HIV/AIDS is the fact that HIV/AIDS induced shocks embody a reciprocal determinism: the insecurity, poverty and hunger that stems from HIV elevates the probability of high-risk migratory and sexual behaviours (Chopra, 2004). The triad of illness, environmental factors and human behaviour effectively co-evolves over time. The epidemic thereby reinforces the conditions of its own perpetuation.

## **The effects of HIV/AIDS: Differential and distributed**

The literature on the consequences of HIV/AIDS in rural Africa, discussed previously, enumerates the effects of the epidemic. Yet the highly adverse consequences of HIV/AIDS on households and rural livelihoods have been described in detailed, they are far from homogenous. Not only are there substantial national and regional differences in the distribution of HIV/AIDS, but HIV-related morbidity and mortality interact with a range of *a priori* individual and household characteristics. Pre-illness factors such as wealth, social status, education or mobility mediate the consequences of the epidemic, for “The effects of mortality appear to be complex in that they depend importantly on initial community conditions such as the level of mean education, wealth, connectedness with markets and infrastructure, and dependency ratios” (Jayne et al., 2005. p. ii). Drimie (2002) counsels that failing to take a disaggregated understanding of community level characteristics may impede understanding the epidemic's effects. Furthermore, as HIV is caused by behaviour choice rather than a random event, efforts to quantify these effects are often confounded by the spectre of underlying, hidden behavioural determinants: although these are of less salience in the current qualitatively-orientated inquiry. A final difficulty in considering the effects of HIV/AIDS related mortality is the diverse and often incommensurate metrics often used across various studies, including: income, agricultural production, security of tenure, household out migration and household dissolution. Notwithstanding these difficulties, the manner in which the effects of HIV are both differential and distributed is considered in what follows.

## **HIV/AIDS effects as differential**

Three axes along which the effects of HIV/AIDS are differentiated are described in what follows. These include population density (a proxy for labour supply), initial levels of wealth, education, and household factors such as the headship status (of the AIDS ill), all of which can substantially mediate the relationship between adult mortality on one hand and household level welfare on the other (Jayne et al., 2005). The subsequent discussion considers the literature on Africa quite generally and reflects on the specificity of the South African context, which displays both convergences and differences with findings from elsewhere on the continent.

### **Population Density**

The first dimension that potentially influences the negative effects of adult mortality is population density. With regards to agricultural output, declines in the area under cultivation associated with adult mortality tend to be clustered in rural locales with lower population densities. In these sites declining labour supply, rather than the paucity of arable land, becomes the predominant production constraint. However, in areas with relatively higher population densities the effect of adult mortality on agricultural output is far less pronounced. Population densities are comparatively high in the rural Eastern Cape, approximately 72 people per square km in the focal rural district (Eastern Cape Provincial Government, 2007); accordingly, the loss of labour is less likely to be an insurmountable obstacle to agricultural output. Even with regards to the unremunerated care work that is central to many households, Booysen and Bachmann (2002) suggest the dearth of formal employment creates a pool of potential carers able to replace those lost to HIV/AIDS.

### **Household Wealth**

The second of dimension of differentiation is wealth. In a study comparing rich and poor male and female-headed households in Kenya, Yamano & Jayne (2004) found that only households in the lower half of the income distribution (predominantly female headed) displayed a shift from commercial to subsistence agriculture with the death of their spouse. Hence, the evidence from agrarian African societies suggests wealthier households do not experience statistically significant mortality effects following prime adult mortality, whereas poorer

households do (Hunter et al, 2007). However in a study conducted in South Africa (Hosegood, McGrath, Herbst & Timaeus 2004) points to more limited effects and suggests the probability of household outmigration or dissolution is relatively unaffected by the headship status of the deceased.

## Educational attainment

A third and related dimension along with the effects of adult mortality on household well-being are differentiable is the deceased's level of educational attainment. In the relatively early history of the epidemic educational attainment was positive correlated with HIV risk, a correlation has since declined and largely inverted (Chapoto & Jayne, 2005). In terms of the effects of HIV, the experience from Southern and Eastern Africa suggests that where the deceased household member had a high level of educational attainment, their mortality constitute a larger shock *vis-a-vis* those with less educated household members. It is hypothesised the former are more likely to be earning cash incomes.

## Headship status

The fourth and final dimension along which the effects of adult prime age mortality can differ is the role of the deceased within the household, and their headship status. In their examination of five sub-Saharan African countries with high rates of HIV, Mather, Donovan, Jayne and Weber (2005) find that in four out of five country cases the majority of prime age adult mortality was not amongst household heads. The burden of mortality was, in other words, predominantly amongst adults other than the designated household head. Furthermore, Kenyan data suggests that households experiencing the death of an adult other than the household head tend to attract new adult members; alternatively, the death of the household head or their spouse elevates the possibility of the outmigration of household members (Heuveline, 2004). In addition the data suggests, "the *ex post* land/labor ratios and household incomes of affected households are quite heterogeneous, the mean and median values of which are similar to those of households without a death" (Mather, Donovan, Jayne, Weber, 2005 p.1290). This cast into question the usefulness of the homogenous concept of 'affected households'.

These dimensions of differentiation can be viewed in relation to the South Africa data on the effects of adult mortality on household composition. The

metric of agricultural output is less useful in South Africa, but the area-based demographic surveillance data suggests households with adult mortality are three times more likely to dissolve, even when controlling for factors such as household size and economic status (Hosegood et al., 2004). Hosegood et al. (2004) argue the risk of household dissolution is relatively independent of the deceased's age, gender, or cause of death (viz. natural, violent or accidental deaths). The probability of household dissolution is similarly unaffected by the death of children; it rises only with multiple adult deaths. This is not however to say that adult deaths are insignificant in driving changes in household composition, as approximately half of adult deaths in the research site were judged to be AIDS-related, cumulatively elevated mortality rates will ultimately produce higher rates of household dissolution (Hosegood et al., 2004). What the evidence does suggest is that relatively resilient family and social systems have sheltered their members from the worst of the epidemics anticipated negative effects thus far (Heuveline, 2004; Hosegood & Ford, 2003).

Evidence from elsewhere on the continent suggests the evidence household dissolution in the face of HIV/AIDS is equally varied. Mather, Donovan, Jayne & Weber (2005) document relatively low attrition rates amongst Kenyan households (5.6% from 1997 to 2000) and Malawian households (14% from 1990 to 2002). In light of methodological challenges involved, the actual proportion of household dissolution is thought to be lower than the quoted attrition rates (Yamano & Jayne, 2004), however some counter this and suggest that that widespread household dissolution may generate systematic underestimates in their own right (De Waal, 2004). A rather more common response to mortality is for individual household members to out-migrate, Hosegood (2004) speculates, "households unable to cope in situ may also be unable to migrate successfully and go on to dissolve instead" (p.1589).

## **HIV/AIDS effects as distributed**

The effects of adult morbidity and mortality are not only differentiated, they also have a distinctly distributed quality. Although most apparent at individual and household level the consequences of HIV/AIDS reverberate within much wider circuits of influence. The nature of social networks and reciprocity were discussed in detail in the preceding two papers (Neves and Du Toit; 2008, Neves, 2008), including the manner in which these allow rural households to distribute risk and capture livelihood making opportunities. Households constituted their livelihoods in dense systems of social reciprocity and exchange. The reciprocal social linkages between households and distant locales mean

household shocks are frequently ‘transmitted’ to households within broader, often spatially extended social networks. HIV/AIDS illness is therefore marked by a fundamental, recursive impact between households and broader community. Samuels, Drinkwater and McEwan, (2006) estimate that on average, the HIV-related deterioration of a single household can adversely affect four to five other households. In this way, even households where members are uninfected and ostensibly free of the illness may still be HIV ‘affected’. Hence, relatively low or seemingly contained individual household level impacts may obscure much more prevalent communal level stresses.

The second paper (Neves, 2008) described how social reciprocity is frequently steeped in long histories and often entails processes of provisioning for infirmity or eventual rural retirement. These cycles of outmigration and rural return have an age cohort quality, and contribute to the ‘domestic cycle’ of household development. This social exchange, crucial to survival in an impoverished context, operates within circuits contoured by clan and kinship lineages, yet other forms of social connectedness including friendship and neighbourliness also exist. In the second paper (Neves, 2008) the central role of the village health workers was described, along with the manner in which these interpersonal relationships of biomedical modernity are often built up on the palimpsest of prior kin or affinal relatedness.

While social reciprocity and exchange is a key quality of social existence and crucial to the survival of often vulnerable and impoverished households, it is useful to make explicit its ambiguous quality. Reciprocity within social networks can serve both an ameliorative, risk diffusing function, but can equally be extractive and serve to transmit shocks. The demands of social reciprocity are furthermore bound up with notions of propriety and the need for recipients to demonstrate their eligibility as worthy recipients of beneficence (Sharp & Spiegel, 1985). In a study describing the experiences of HIV/AIDS some 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” (Hosegood, Preston-Whyte, Busza, Moitse & Timaeus, 2007, p.1253). The combination of stigmatised illness and their diminished material base thereby undercut their ability to make claims on others.

Finally, while the manner in which the effects of illness and death are distributed between households has been suggested, it is equally useful to reflect on intra-household dynamics. As the burden of care work and social reproduction does not fall equally on the shoulders of all household members, the effects of illness and death are not homogeneously felt within the household. In the context of

morbidity and mortality, dependency ratios and care burden may increase; burdens that are disproportionately borne by women and the elderly (Schatz & Ogunmefun, 2007). Moreover, even statistically stable dependency ratios do not imply the absence of change. De Waal and Whiteside (2003) propose the 'effective dependency ratio' may shift, due to the fact that the prominent classes of caregivers (such as young adult women who are highly susceptible to infection) may be present, yet incapacitated.

## Household responses and coping

Up to this point, the consequences of HIV related morbidity and mortality have been considered, along with the manner in which these effects are both socially differentiated and communally distributed. In what follows the notion of responses to HIV/AIDS are considered in a little more detail. The HIV/AIDS-ill return migrate for a number of reasons, including accessing emotional succour, treatment and resources as described in paper two (Neves, 2008). It was furthermore suggested this return needed to be understood relative to local practices of household making and against the backdrop of the fluidity and contingency that marks household composition. The rubric of 'responses' can characterise reactions to adversity, ranging from the individual psychosocial realm to the household level, but as suggested in paper two (Neves, 2008) the rubric of coping can be subject to critical questioning.

Firstly, the distributed quality that often marks the effects of HIV-induced shock, noted in the previous section, can equally be applicable to decision making. As suggested in the preceding paper this serves to obscure the communal and distributed quality of much decision making. Rugalema (2000) poses the question "Should we talk of households, individuals, therapy management groups, or even community with reference to strategies invoked in confronting illness" (p.541). Secondly, the rubric of coping embodies the suggestion of deliberate or pre-formulated strategy, obscuring its often contingent and *ad hoc* quality. Particularly in the face of terminal illness and livelihood threatening shocks, decision-making may be marked by contingency and compromise and be less rational than conventionally assumed (Rugalema, 2000). Thirdly, judgements of coping are often highly dependent on the particular temporal framework selected. An event which may, on cursory examination, appear to be an adaptive example of coping may, within a larger framework, prove to be a gradual downwards trajectory. Therefore, responses to HIV/AIDS induced shock are complex, multi-dimensional and explicable in terms of various levels of analysis.

# Methodology

Despite the proliferation of research on HIV much of it relies on cross sectional research designs, which impose substantial limitations on identify antecedent events and trans-temporal aspects of HIV/AIDS. As the consequences of HIV/AIDS are both cumulative and longitudinal, area-based forms of inquiry such as Demographic and Health Surveillance Systems are of utility. However for a relatively focused and contained study (such as the present one), an in-depth qualitative approach can be equally useful. In it, the objective is to go beyond ‘first order’ consequences of HIV/AIDS illness and death, in order to explore the interplay between morbidity and mortality on one hand, and the particularity of the context on the other. The methodology of the present study, described in detail in the second paper (Neves, 2008), is focused on building a nuanced understanding of HIV related dynamics, rather than quantitative notions of statistical representivity. Sensitive interviewing introduces the opportunity to retrospectively reconstruct the antecedent events and dynamics, in order to better understand longitudinal dynamics. In addition, semi-structured qualitative interviews are well suited to the pragmatic and ethical demands of conducting research in the context of stigmatised illness. A final advantage of the flexibility in the method used is that it enabled the research team to draw on its previous experience of, and work within, the research context.

The project drew on two distinct data sets. A single case study was derived from the data collected during an earlier enquiry in the focal research context, while the remainder of the cases were sampled anew. Households were sampled on the basis of

- having had a prime age (18-49 year old) member who was ill or who had died,
- the affected individual was locally resident (viz. in the rural homestead),
- the illness or cause of death was either confirmed to be HIV/AIDS or strongly consistent with an HIV/AIDS related aetiology.

With regard to the criteria of HIV/AIDS related aetiology, the research team loosely drew on the WHO HIV (2007) guidelines of weight-loss, diarrhoea, and fever. It also remained attentive to accounts of ancillary, plausibly HIV related immunocompromised symptoms such as skin lesions, lymphopathy, shingles, thrush and pulmonary complaints. As approximately a third of HIV patients are co-infected with tuberculosis (Corbett et al., 2003), the research team remained alert to reports of pulmonary complaints and symptoms of tuberculosis. Although this process of judging mortality to be HIV/AIDS related illness was somewhat impressionistic, no form of biomedical screening was used nor were

‘verbal autopsy’ instruments administered to adjudicate reported 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, marked by infirmity and incapacity, would be similar for HIV/AIDS and many similar, debilitating chronic ailments. Hence, it was not important to distinguish, for example, between HIV and ailments 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, cerebro-vascular 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 either volunteering this diagnosis, or village health workers and clinic sisters proffering this as likely on the basis of their professional opinion.

It is useful to clarify the predominance of cases of mortality. This inquiry selected mostly households that had experienced the death of a member for two primary reasons. Firstly, in light of the often fluid and oscillatory migration between urban and rural death can stochastically occur at either site; hence deciding if a particular case study will be an example of urban or rural mortality can best be decided post mortem. Secondly, examining households *ex ante* to AIDS mortality often facilitates an understanding of both the consequences of morbidity and mortality, rather than just the former.

Finally, it is useful to reflect on the methodological challenges posed by household dissolution. If households are taken to be the primary sampling unit, these cases of dissolution are extremely difficult to capture by any modality other than an area based demographic surveillance approach. Dissolved households would, by definition, cease to exist and be beyond the purview of inquiry. This research fortunately was able to sample a household unit that dissolved in the face of AIDS mortality, and was subsequently reconstituted.

The sequence of fieldwork practice has been discussed in detail elsewhere (Neves, 2008) and is not repeated here in the interests of brevity beyond stating that once access to the site was negotiated via relevant gatekeepers, the village based community health workers and clinic sisters were key informants in identifying focal households. Despite this, the research team took a number of precautions to ensure the focal research participants of their anonymity and prevent the community health workers unduly influencing case study selection. All names are pseudonyms.

In terms of the analysis, interviews with household based informants were broadly orientated to elicit 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. Mobility 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.

The findings are considered in what follows.

## **Findings**

The case studies are recounted in what follows. Each case study is synthesised from the empirical material collected, and followed by a short commentary that seeks to contextualise, elaborate on, and draw attention to salient aspects of the case study. The case studies consider the effects of HIV/AIDS related mortality and the factors that mediate these effects.

### **Case 1. Thobela**

This interview was initiated with the brother and mother of the deceased Thobela, at the mother's large, comparatively prosperous looking homestead. (The brother was included as case study 1, in Paper two). 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. Thobela ailed and died here a few months earlier while her gaunt and ill looking brother, Phumile, has himself only relatively recently returned to the maternal homestead. Thobela and Phumile's mother, Magaza, is the nominal household head. To aid reader comprehension the household 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 also enumerated as members of the extended household. These included Magaza's 28 year old daughter, who worked at a jeweller in Johannesburg (Phumile's half sister), and has a 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 daughter of the deceased sister Thobela. The child used to live with her mother in Johannesburg.

Magaza grew up and married in a distant village, where Thobela and her brother Phumile 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 was originally from this village, and there was the suggestion that this move represented a fresh start for their new marriage. Her second husband (Thobela's stepfather) worked as a foreman at a Gauteng municipality. He returned to the village after being medically boarded in 1993 and died of 'cancer' like symptoms in July 2006. Consistent with local practice, Magaza mourned her husband for 12 months, and her *ezila* (coming out of mourning ceremony) was conducted in July 2007. 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 a month earlier.

Thobela continually migrated between the village and Johannesburg since the early 1990s, returning several times during each year. She engaged in a range of

informal and part-time jobs, and secured a temporary contact post at the municipality as a sweeper around 2005 / 2006. She worked for approximately a year, before growing ill with fevers and weight loss. She stopped working in February 2007 and returned to the village in March 2007 to recuperate and because she was unable to support herself in the city any longer. Her return was consistent with her established pattern of oscillation between her mother's homestead and her urban shack. She was very ill on her return and twice, in quick succession, admitted to the public hospital in a nearby town.

She deteriorated further until mid 2007 when her mother, paid R800 for Thobela to be taken in a hired 'bakkie' (pickup truck) to a private doctor in a more distant town (approximately two hours uncomfortable drive on unpaved roads). Magaza did not think her daughter was receiving a high level of treatment from the local public hospital that, reportedly, only seemed concerned with discharging her as quickly as possible. Magaza reports that it was only at this point that she learnt her daughter was AIDS ill, from the private doctor. Nobody at the public hospital had reportedly ever revealed this to her, she complained. Returning home from the private doctor on 16 July 2007, Thobela died at the rural homestead that very evening. Magaza reports that if Thobela knew she was AIDS ill she deliberately she hid it from them, by claiming to have TB.

Thobela's illness and death had a number of effects. It 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, Thobela's death came during the mourning period for her husband; cumulatively she described these two bereavements as very stressful. (Mourning for ones husband is a year long event; mourning for a daughter is of a month's duration). The successive bereavements left Magaza feeling conflict and unsure which of the two deceased to direct her focus on: her daughter's death 'collided' with the mourning for her husband and 'confused and upset' her (fieldworker's translation). The strain of the death was further exacerbated by the fact that Thobela 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. Her brother made fruitless enquires at the municipality where she worked for these employment benefits. Hence, 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, lived in Johannesburg and is reportedly unknown to the family.

The narrative of Thobela's older brother Phumile echoes much of the denialism evident in Thobela's trajectory. Phumile lost his employment in Johannesburg in 1992, fell out with his wife at the rural matrilocal site, lived with his

Johannesburg based step-brother for a year, before finally arriving to the maternal home in December 2006. Significantly, Magaza continues to be unambiguously viewed as the household head; Phumile is simply a displaced, ill son in need of care. The precedent for, and cultural appropriateness of, his residence at his mother's house is far less firm than it was for his late sister. Initially Phumile scrupulously avoided returning to the maternal home, and has continued to be plagued by ill health and hospital admissions since his return. Gaunt and ill looking, Phumile attributed his and his sister's illness to poisoning by their malevolent stepfather.

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. Thobela never earned enough to remit money, so her death has not constituted an economic shock to the household. Magaza reported that the family receives no assistance from the village, and that they have no cows or goats, but have a flock of 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**

The case study illustrates presents the case of the deceased Thobela to examine the consequences of HIV related death. The informality of the conjugal contract means her child's paternity is unknown to the family, and beyond the possibility of any claims. In addition, Thobela's case (and that of her brother, Phumile) was marked by a denialism concerning their illness. The case furthermore illustrates the complex negotiating of stigma and stratagems to avoid it. Ancillary inquiry also pointed to the attributions of witchcraft and poisoning Phumile appeals to, in order explain both his and his sister's illness. Finally, as Thobela was not central to the continuation of the household, her death constituted limited material shock to the household. While Magaza's doubtlessly grieved at her daughter's death, her account of the bereavement 'colliding' with (longer period) mourning for her late husband, suggests the complexity and differentiation surrounding the affective economy of death.

## Case 2. Thembekazi Matibane

The three Matibane siblings were included in previous rounds of the research team's work in the district. The interviews were conducted with the three teenagers at their homestead compound, consisting of two collapsed mud brick buildings and a single, small round hut (rondavel). The cramped rondavel was furnished with a single bed, a table with cooking paraphernalia, and a rickety bench. In a 2001 research visit, the three Matibane siblings (15 and 12 year boys, and a 13-year-old girl) were being cared for by their ill maternal grandmother, while their mother, Thembekazi Matibane, worked as a security guard in Johannesburg. (The children never knew their father, only that he is dead). The grandmother, the informants recall, was unable to eat, and displaying cancer like symptoms, only to ail and die in 2002. The children's mother returned to the village for the funeral; shortly after this, she herself grew ill. She wasted away with a litany of immunocompromised-like symptoms such as skin lesions and stomach complaints, and 'fits' (fieldworkers explanation), to die in 2003. In this time, she undertook several trips to private doctors in town and was admitted to hospital, to be discharged thereafter. Neither the siblings nor their guardian reportedly knew what was wrong with their mother, only that she was ill and deteriorated steadily. Her then 15-year-old eldest son devoted much of his time to caring for her and was forced to repeat a grade at school after failing.

With the successive deaths of their grandmother and mother, the three siblings recall a period of about nine months from late 2003 to 2004 as being a particularly difficult time. In this period, they were aided by the mothers of two of their friends, one of whom is a local teacher. The three siblings alternated between collecting raw food from these two sets of benefactors that they then prepared. The siblings were then finally dispersed; the girl was dispatched to two successive uncles, before joining the youngest boy in the household of the great-aunt, within the village. The elder boy looked after the house of distantly related kin (who migrated to Johannesburg), for a small sum each month and often went hungry. In response to this problem, the three teenagers acted to reconstitute the shattered household, embarking on a successful campaign to convince their extended family to allow them to collectively reoccupy their mother's vacant house.

Central to the three orphan's ability to reconstitute their household was the fact that their great aunt succeeded in securing state Foster Care Grants for the two younger children, amounting to just over R1000 a month. (The eldest was no longer a minor in 2005, and therefore ineligible for a grant). Overseen by

attentive Social Development officials, the orphans were saving approximately half their income in newly opened bank accounts each month, and bought food, paraffin, clothes and paid school fees with the balance. As two of the three dwellings in their modest homestead compound had collapsed (one after a direct lightning strike), the two brothers shared the small hut, while their sister slept at the homestead of the teacher benefactor. However, the 16-year-old girl viewed herself as part of her brothers' household; the siblings shopped, cooked and ate together.

The process of reconstituting the household was enabled both by the social grants and by the teenagers' ability to draw on their great-aunt as a local social political guarantor. Yet this process was not without its difficulties, despite their obvious affection for each other, the brothers believed that the girl has a different paternity, and this has been a source of sibling taunting. Other kin relationships proved even more contested: a distant uncle laid claim to the homestead in 2005 (this threat had dissipated when the team visited a second time in 2007). Moreover the teacher who allowed the girl to sleep at her house, declined to be interviewed by the research team. She explained that the extended family sought any opportunity to abrogate material responsibility for the three adolescents. If seen to be talking to resourced researchers they would suspect her of receiving recompense for aiding the girl. Finally, there has also been intermittent conflict between the teenagers and their elderly great-aunt, whose authority they challenge. The youngest boy had a history of school truancy, and the girl became pregnant in 2006, only to have her neonate die. This distressed the great-aunt, who was at pains to remind the research team that she is not even their 'real' (genealogical) grandmother – implying that their claims on her protection were actually fairly weak.

By 2007, the now 18-year-old girl's grant was extended, on the grounds that she was still attending school and therefore a dependant. She made inquiries to have herself designated payee of her own foster care grant, which the grant officials duly refused, an episode which reflects the contradictions between her legal status as a 'dependent' in order to receive the grant, and her assertions of independent personhood.

## **Comments**

This case study shows the dissolution of a household unit in the context of two successive deaths (the siblings' grandmother and mother). The description of the mother's mortality is consistent with HIV aetiology and the care burden was

largely carried by her teenage son. The children effectively became orphans and were for a period dispersed amongst extended family members. However, they were able to reconstitute their household and reoccupy the homestead through their agency and their ability to access two foster care grants and the willingness of a distant great aunt to serve as a social guarantor (and nominal recipient of the grant). Significantly, the most vulnerable of the three siblings, who was aided by this reconstituting of their household, was the eldest (adult) sibling. Since reconstituting the household, the siblings have had to deal with tenurial insecurity and conflict. The case study also suggests something of the working of entitlement, and the need to manage social obligation. It is reflected both in the teacher benefactors reluctance to be seen to be talking to the research team (less the extended family displace further responsibility onto her), and the great aunt's disavowal of responsibility for the three young adults.

### **Case 3. Vuyiswa**

This research was conducted in a well-built and freshly painted rural compound, typically associated with a household where a member secured extended urban employment. Forty four year old Vuyiswa received the research team seated on a grass mat in her 'reception' hut. She was dressed in black mourning clothes and had the sullen countenance of a recent widow. She barely raised her voice above a whisper (an embodied manifestation of her recent grief), which necessitated the fieldworker, who sat alongside her. The household consists of Vuyiswa, and her 20-year-old daughter, with her infant (Vuyiswa's grandchild). The extended household consists of two adult sons, 27 and 23 years old, who both live with an aunt in Johannesburg.

Vuyiswa's 48-year-old husband was born in the present village, into which Vuyiswa married. They have occupied the present homestead since 1979, which used to be his parents house. Early in her marriage, his parents lived with them. Vuyiswa's husband used to regularly remitted money, which enabled them to build the additional structures. She used to visit him in Johannesburg, but remained otherwise resident in the village.

Her husband reportedly worked at 'Western Areas' mines as the driver of an 'underground train', and lived in a hostel. In 2004, he became ill, with lesions on his feet and fatigue which made him struggle to work. For most of 2004, men from his village, who lived with him in the hostel, nursed him. He returned to work at the end of 2004, but suffered from shortness of breath and various respiratory complaints. It was at this stage that he was medically boarded and

returned to the village. While resident in the village, he used to get his money through TEBA (the mineworkers agency) every month. Vuyiswa produced a small pile of papers, sifting through it and produced a standardised letter from the occupational health centre of a large gold mining conglomerate regarding her husband. Amongst a list of various ailments, 'PTB' (Pulmonary Tuberculosis) was circled. (Although skin lesions are seldom associated with TB, and possibly point to a more complex condition).

Once Vuyiswa's husband returned to the village, he continued to suffer from respiratory complaints and consulted various private doctors in Mount Frere and Matatiele. He was incapacitated by ipika (breathlessness) and 'asthma' like symptoms (fieldworker's interpretation). At this stage, he was taking medication from the clinic in the village but Vuyiswa suggests it did not prove very effective. When her husband felt well he would collect the medication himself, but sometimes she would go, or the nomakhaya (village health worker) would drop it off. He finally became very ill and was taken, in a wheelbarrow, to the road and then via quqa (informal, pick-up truck taxi) to a local hospital. He remained in hospital for a week, and died in the second week, in October 2006. After his death, the TEBA payout book was changed to Vuyiswa's name and she has continued to draw his small monthly pension (similar in size to the state old age grant she indicated).

In terms of the aftermath of his death, Vuyiswa describes being very upset and crying almost continually. She explained that while her material condition has not changed substantially, and she has not been 'disrespected' (fieldworker's translation) by the children or his family, she is still struggling. She reportedly finds it difficult without her husband to talk to and make decisions, as she was unaccustomed to this. His death has resulted in no enduring changes to household composition; the children from Johannesburg came for the funeral, but subsequently returned to the city. She reported that she was in satisfactory health but that being sad for so long can make one sick.

Presently at the household was the five-year-old granddaughter fathered by one of Vuyiswa's sons. As her son and the child's mother are unmarried, the child lives at the matrilocal residence elsewhere in the village, yet frequently comes to visit. Vuyiswa described how she was useful and helped with small chores such as fetching water. She found it difficult to talk at length, and the research team respectfully concluded the interview.

## Comments

This was a difficult interview to conduct and the informant was visibly bereaved and unable to speak at length. Furthermore, psychological subjectivity is constituted against the backdrop of socio-cultural context and patriarchy encodes an asymmetry of grief. Xhosa cultural mores require a full year's mourning by a widow for her husband; but a widower generally mourns his wife, child or parent for a shorter period. In essence, this was the death of the household head, in a 'traditional' household form stretched along the traditional axes of urban male migratory labour. Although the documentary evidence confirms a case of TB, the other symptoms reported are possibly suggestive of an HIV aetiology, although it is beyond the scope or concern of the research to establish this with any real degree of certainty. In the presence of corporate employment 'death benefits' Vuyiswa's assessment of her situation is telling, her material situation remains unchanged but she misses the companionship and authority of her late husband. Her catalogue of the post death situation, also points to the (non-material) vulnerability a widow might potentially be exposed to including: 'disrespect' from the family and children, and social marginalisation. In this case, the high status of the deceased (as household head) suggests his death is of significance to the household's future trajectory. Yet the relatively recent nature of the bereavement makes it difficult to discern these dynamics.

## Case 4. Bongani

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. She has a total of four older daughters; the eldest is married and lives in a regional town (two hours of travel away). Resident with this daughter are Kalima's older teenage children, who are enrolled at a local school. The fourth of Kalima's older children is an adult daughter who lives in Johannesburg with her boyfriend and child. Kalima was described in the previous paper (Neves, 2008), but it is the story of her transient boyfriend Bongani that is the focus of this narrative.

Kalima married her municipal worker husband in the mid 1970s, he returned to the village in the early 1990s had a stroke, and died in 1999. His 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 her with the funeral expenses. Kalima describes this as a difficult time during which she struggled materially.

After her husband's death Kalima had a dalliance with Bongani 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 Bongani and 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. Kalima's friend and benefactor Sindiswa explained that although Kalima was hardly the first widow to become involved in 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 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.

Bongani 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 and nomakhaya Sindiswa recalls resigning herself to looking after the children. While the younger boy slept at her house, the older girl slept at a relative's household, and both children regularly ate with Sindiswa's family. Sindiswa recalls that her husband would complain about supporting the children and routinely threatened Sindiswa that he would chase them back to their mother, although he never did this. After several months, Bongani 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 Bongani revealed he had been diagnosed with HIV 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 Bongani to the home of a policeman in another village (who shared a clan name with Bongani). The policeman in turn returned Bongani to his own family where he soon died thereafter. This, Sindiswa thought, is how Kalima contracted 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).

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 neurologically 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 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 everyday (standard treatment for TB patients who have defaulted on oral medication or patients with confirmed or suspected 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 her HIV. (Although 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's 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.

Within this case study, their 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 enquiries, 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 (primarily her married daughter) were angry with her for becoming ill through her sexual indiscretion.

## Comments

This case study of Bongani is incomplete and unclear at several points but the elisions surrounding Bongani's case reveals something of the gendered nature of vulnerability. Bongani is elusive, he appears in the village and ebbs away when ill, to die. Some of this reflects the limitations of the research process and the task of retrospectively reconstructing the narrative of a research subject post mortem, but it can also be suggested that it reflects the analytic elusiveness, transient, and even absent nature of many men. The enduring image of Bongani is the abject spectre of him, terminally ill, being taken to clansmen via wheelbarrow, and passed on through several intermediaries to his kin. Although this case shows something of the workings of clan based loyalties, it suggests how social and care networks are frequently highly gendered and feminised.

The opaqueness of this entire episode is accentuated by the fact that Kalima's candour in all but her relationship with Bongani and speaks to the working of stigma. The chief 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, suggest something of the mores and norms that prevail in this context.

## Case 5. Xolile

Tall, with a dignified presence, thirty two year old Xolile lived in a neat block-built house in a small village, in close proximity to a small Eastern Cape town. Members of his extended family occupied adjacent residential sites in the village. While idealistically described in an idyllic agrarian register by its residents, receipt of various municipal services and the nearness of the village to town, meant the villagers and their livelihoods were decidedly urban orientated: many worked, shopped and schooled in the nearby town. The son of a minor

civil servant, Xolile worked for years in as a tour guide and driver in the Transkei's Wild Coast region. Although erratic and seasonal, his employment was moderately well remunerated and enabled him to build up his comfortable homestead. His seven-year-old son from a previous relationship lived with him, and by 2002 Xolile was assuming responsible for several nephews and nieces who moved quite fluidly between his homestead and the adjacent homestead of his mother. Xolile oversaw the nephews and nieces as their parents were, by his description, variously: impoverished, inattentive or employed in distant urban centres. Although Xolile was stern, the children appeared were very fond of their uncle. Xolile traced his ancestry to the chieftaincy. His social status a member of the local petty elite was cemented by his lineage, matric education, church going, employment, and friendship with various local government officials and business leaders. His social position conferred not only a sense of social superiority, but also animated various acts of beneficence to other lower-status community members, such the frequent lifts offered to hitchhikers and his efforts to draw potential social grant recipients to the attention of social development officials.

Xolile married in 2004, his wife was herself of a middle class family and studying to be a social worker. After their marriage the homestead became furnished with new furniture and consumer electronics, much of it financed through higher purchase. Although his income was erratic, Xolile explained the necessity of his large 'lobola' (bridewealth) payment, and the newly acquired furnishings in terms of the social respectability they conferred. These lead people to 'respect you' he explained, and indicated the need for his in-laws to view him as appropriately resourced. By 2006, the residents of the homestead included the couple's newly born infant son, along with Xolile's pre-teen son. Also resident was a distant 11 year old nephew (twice removed) who had proactively sought to join the household when his own mother and grandmother died leaving him to reside with an uncle with whom he did not get on. The nephews and nieces continued to alternate between Xolile's homestead and that of his mother, but his responsibility to a young teenage niece irrevocably increased when her mother (Xolile's sister) died after a short, mysterious illness. Although the child slept at the grandmothers (Xolile mother's house), he paid her school fees and bought her clothes. At this stage, Xolile's wife was studying in a distant city, returning home most weekends. Her studies were combined, with relatively low paid (around R2500) work from 2006. Her newborn baby stayed with her immediately after his birth, but soon became resident at the homestead. Xolile employed a succession of young women (typically at around R400 a month) to look after the child, particularly when he himself had to work. These arrangements generally proved unsatisfactory to all concerned and several

of the young caregivers absconded or were fired. With the long absences of Xolile's wife from the home, he reverted to his pre-marriage pattern of domesticity. Xolile took obvious pride in his homestead and he and the boys cooked, cleaned, shopped, and maintained a vegetable garden. Throughout this period, Xolile complained of suffering from 'stress', a diffuse complaint marked by insomnia, anxiety and gastric ulcers. He complained of being bewitched, and attributed this to 'jealousy' on the part of other villagers who envied his success. He sought to deal with this by paying for potions from an herbalist, hosting several (Christian) prayer sessions at his home and even consulting a private medical doctor. The powerful sedatives the doctor dispensed temporarily enabled him to sleep.

In 2006, several of Xolile's contacts went unrenewed, and remunerative work became even more erratic. With the last of his accumulated savings, he purchased an old second hand vehicle and hoped to run a local quqa (rural pickup truck-based taxi) service. However, the cheap vehicle proved mechanically unreliable and he sold it at a loss several months later. He remained intermittently ill, and suffered from a diffuse range of maladies including lethargy, various stomach related ailments. The reported insomnia, anxiety and 'nerves' that marked his psychological condition was exacerbated by the fact that by 2007 work had ceased, and the household was increasingly reliant on his wife's income. At this point, he borrowed R5000 from a former employee and planned to buy a large marquee-type tent and rent it out for the weddings, funerals and various other traditional ceremonies that occur within the village almost every weekend. His plan was however interrupted by the fact that towards the end of 2007 he grew very ill and utterly incapacitated and in need of constant care. His wife took time off work to nurse him. He consulted a private medical practitioner who diagnosed him with anaemia. His condition deteriorated further until his wife admitted him to a distant public hospital where he was diagnosed with TB and HIV positive. The private medical practitioner, and the constant travel to the distant hospital were a considerable drain on their resources and he and his wife drew down the R5000 loan, having never purchased the marquee. Although resident in the Eastern Cape Province, they chose to regularly undergo the hour-long commute into an adjoining province, which they perceived to offer up a much higher quality of care. However, a desire to avoid stigma cannot be precluded. Getting onto ARVs was an expensive exercise even at the public state facility, as it required his physical and neuropsychological condition (he was delirious and disorientated) be stabilised, before he and his wife return several times to the distant hospital for counselling. Xolile suffering from neuropathy in his feet was weak and experienced significant wasting, which required expenditure on nutritional

supplements. He confided in several family members and friends about his HIV positive status, but has avoided discussing it more widely or attending the local clinic.

At the end of 2007, he was still too ill and weak to take up renewed offers of employment. In reflecting on his condition he believed it to have been sexually acquired before his marriage, but explained how he was lured into a dalliance through witchcraft, perpetrated by 'jealous people'. Xolile's understanding of his condition thereby reconciled attributions of witchcraft with conventional biomedical understandings of HIV causation. He reported his wife and young son have tested HIV negative and despite the occasional tension between the couple, she continues to support him, emotionally and materially. His wife continues her erratically remunerated work but money is a constant problem and their various creditors have sought payment. He is unable to borrow any more money but has resisted selling off any of his assets particularly his consumer durables, as his 'enemies' would derive too much satisfaction from this. His elderly, pension-receiving mother has increasingly assumed responsibility for the grandchildren, but her own petty remunerative activities have suffered as a result.

## **Comments**

Xolile's deteriorating ill health is relatively recent, so it remains to be seen what trajectory the household's welfare will assume. The case study points to Xolile's deteriorating mental health status associated with his HIV-related ill health. The case study also demonstrates the negative material affect of HIV related ill health, as it weakened the financial base of Xolile's household. Not only did he stop working, his wife's work and mother's sewing income have also been interrupted as care burdens were reconfigured within and between the households. The case reveals something of the cluster of practices, consumption (domestic consumer durables) and the sense of personal identity invested in social respectability within the focal research context. As a result, of this Xolile has resisted selling off any of its assets despite the household's weak material position.

## Case 6. Nolubabalo

The homestead compound of Thembela is located in a distant village a two-hour drive from the nearest town or tar road in the Eastern Cape Province. Sixty-two year old Thembela shares to compound with his 58-year-old wife, two adult children and four grandchildren. Despite the fact that Thembela is relatively unusual in earning a comparatively modest monthly stipend (approximately R1500) as a low ranking traditional authority; his homestead is of strikingly poor quality. Devoid of the usual material accoutrements of a headman, Thembela's homestead is small and decrepit even compared to households with comparatively less income. The research team was initially puzzled by this, but later came to understand that not only was the household relatively disorganised, Thembela and his wife were drinkers. Within this domestic context the focus of the case study was on Thembela's daughter Nolubabalo who died in her mid-thirties in 2005, and whose child (viz. Thembela's grandchild) continues to reside at the homestead.

Of the four grandchildren resident at the homestead, two are the children of Thembela's 32-year-old son, one is the child of his 25-year-old daughter, and the fourth, 12 year old Msimilani, is the child of the deceased daughter Nolubabalo. The son's children were born to different mothers. One was effectively abandoned by their mother at the homestead. Although the son initially denied paternity, Thembela's wife reports that the child resembles his father, and they have raised him as their own. There was the suggestion that a male grandchild was welcomed in the house to continue the family lineage. The 25-year-old daughter, Nosibenzi, fell pregnant while in secondary school and gave birth to a son in 2003. Finally, the fourth grandchild Msimilani entered the home after her mother's death in 2005.

Msimilani's mother, Nolubabalo migrated continually between the village and the distant urban centres of both Durban and Johannesburg from the mid 1990s until her death a decade later. Nolubabalo occasionally worked in a variety of informal jobs, including as a domestic worker. Although she reportedly earned insufficient amounts to remit, she would bring the family clothes when she returned at Christmas time. Thembela's family have no kin in Durban, but Nolubabalo would see her distant aunt and uncle while in Johannesburg. By 2002, she was living in a shack in Johannesburg with a man that (the family believed) was not to be Msimilani's biological father. Nosibenzi reported that Nolubabalo's relationship with her partner was apparently conflictual and that he was both possessive and jealous. Nolubabalo would usually return to the village only for the Christmas and Easter holidays but returned pregnant in

2004. She was also ill with various respiratory complaints and 'iband' (shingle-like symptoms), symptoms largely inconsistent with pregnancy. Although Nolubabalo was pregnant and moderately ill, she was not totally incapacitated. She stayed at her parent's small homestead, but unlike most women in the village, she travelled to a nearby town to give birth at a district hospital. Nosibenzi said her sister was encouraged to do this because they were concerned about Nolubabalo's health and the clinic sister strongly recommended it. Nolubabalo gave birth in mid 2005 to a stillborn child and died in hospital shortly thereafter. Nosibenzi indicated she and her mother were very upset by this and do not know why Nolubabalo died. They heard via village gossip that ante-natal testing had revealed Nolubabalo to be HIV positive, although Nolubabalo herself never indicated this to either her sister or mother.

Since Nolubabalo's death, the family have continued to look after Msimilani. The child's grandfather, Thembela, has made enquiries of securing a foster care grant for his child but has been hampered by the fact that they have neither a birth certificate for the child or death certificate for her mother, Nolubabalo. His reported attempts to secure the death certificate from the hospital where Nolubabalo died have proved ineffectual. Despite headman Thembela's (presumably) favourable position relative to the world of documents and administration, he has proved inept at securing social grants for his various grandchildren. Although this might reflect his ineligibility because of his monthly income, he has reportedly made various unsuccessful efforts to secure these. For instance of Thembela's two grandsons (aged twelve and nine respectively) fathered by his son, neither received a child support grant. The eldest grandson had no birth certificate and Thembela reported that his enquires saw him unhelpfully told he had to produce the long absent mother of the child. The younger of the two grandsons' only secured a birth certificate when his aunt, Nosibenzi, masqueraded as the child's mother and applied for the birth certificate. She intended securing a child support grant for her nine year nephew with the newly acquired birth certificate. However, Nosibenzi had already secured a grant for her own child and was reluctant to apply for a third grant for the Msimilani (the deceased Nolubabalo's child). Nosibenzi worried that being relatively young, and claiming to have three children (two of whom were approaching middle childhood) would give the Social Development officials cause to be suspicious of her. They might discover her misrepresentation in which case she would not only face sanction, but lose the grants she was currently receiving. Her cautiousness was strengthened her hearing of crackdowns on welfare fraud on the radio.

Nosibenzi aspires to completing her interrupted secondary school education. Unlike her older brother, Nosibenzi seems relatively attentive to the various children. Her older brother, rumoured to be a drinker, scrupulously evaded the research team. He reportedly works irregularly as a builder in the village. His parents expressed the wish that he would, when his father Thembela became eligible for a state old age pension, take over the homestead and his father's position as a minor traditional authority.

## **Comments**

The case study of Nobubabalo saw her return to the rural homestead while ill and pregnant, to die shortly thereafter. Her death has not had an enduring negative effect on the household beyond the absorption of her pre-teen child into the parental household. Much of the case study charts the subsequent efforts of household members to secure access to state social grants. The case study suggests the differing levels of responsibility household members assume for the new care burdens within the household.

## **Discussion**

In the discussion that follows the case study, data is drawn in order to consider the ex-ante effects of HIV/AIDS on the focal households. In the first part of the discussion, the case studies are discussed in broad terms, and their most salient characteristics highlighted. In the second part of the discussion, the focus is on 'mediatory factors' and their dynamics. In this section, the themes are systematically discussed in more depth, and a heuristic distinction made between mediatory factors at an 'individual' level, followed by those that operate at a 'household' level.

To begin, the consequences of HIV/AIDS across the case studies are characterised quite broadly. Despite the relatively limited number of case studies, they capture much variability. Amongst the most striking elements are the psychosocial dimensions of the emotional distress and grief attendant to mortality and morbidity. Although discernable in all the cases, this is particularly evident in Xolile's mental state and the marked difficulty the bereaved Vuyiswa had on reflecting on the relatively recent death of her husband. Thobela's case further reveals something of the manner in which the biological reality of death interfaces with cultural mores surrounding bereavement. By the mother's account, the distress of mourning for Thobela's

was exacerbated by the fact that it coincided with the year-long mourning for her late husband (viz. Thobela's stepfather).

The case studies also offer up ample evidence of adverse material effects associated with HIV/AIDS, such as Xolile's deteriorating material situation. However, with regards to AIDS related mortality, it did not constitute an economic shock of equal magnitude across all the cases. Within some households the adverse material effects of death, such as medical and funeral expenditure, were relatively transient (e.g. Thobela), or effectively cushioned by accrued assets and employment benefits (e.g. Vuyiswa). Conversely, in other cases, HIV/AIDS related morbidity was a significant negative event drawing down the household's assets and eroding its material base. Morbidity could precipitate changes in households (such as Thembekazi Matibane's household that dissolved after her death). Equally, there were examples of households remaining unchanged (Thobela, Vuyiswa, Bongani and Nolubabalo) in the face of an individual household member's mortality.

Whilst the case studies richly illustrate the workings of social networks and reciprocity, several aspects point to the potentially contested nature of social claims. These include the public disavowal of social obligation by the Matibane sibling's distant teacher-benefactor or the contesting of paternity in the case of Nolubabalo's brother. Finally, the case studies amply illustrate the manner in which HIV/AIDS related morbidity and mortality can be marked by the workings of stigma, even if the dynamics and depth of stigma are by no means uniform.

To this point, the consequences of HIV/AIDS related morbidity and mortality have been discussed in rather general terms. In the section that follows the empirical material is described more systematically, including the various dimensions that mediate the effects and consequences of HIV/AIDS. The focus is therefore not simply on enumerating the effects of HIV/AIDS but reflecting, rather more expansively, on the various dynamics and dimensions thereof. This task entails not only developing a nuanced understanding of the case studies but locating them relative to the contextual specificity of the focal research site. These are discussed firstly in terms of 'individual' level characteristics and secondly in terms of 'household' level characteristics.

# **1. The effects of HIV/AIDS morbidity and mortality: Individual level dimensions**

The effects of morbidity and mortality are differential across cases and are shaped by a variety of factors. Some of these factors, influencing the effect the morbidity and mortality on the household, can appropriately be thought of as properties of the affected individual. Two dimensions are discussed in what follows, the first is the resources that the HIV infected household member had access to; the second is the role and status of the directly affected household member within the household. These two dimensions can significantly shape the *ex ante* consequences of HIV/AIDS related illness and death.

## **1.1 The effects of mortality and morbidity are shaped by the resources to which the infected household member has access**

The first characteristic mediating the effects of HIV mortality on a household are the resources that the deceased was able to command and bring to the household. For example, Vuyiswa's late husband was central to the household - his extended stint of urban employ enabled substantial back investment to his rural homestead. This case might be contrasted with a poorer household member such as Thobela, who did not contribute discernable levels of resources to the household. Her ailing health and subsequent death constituted a shock to her mother's household, by exacting medical and funeral expenditure (and thereby temporarily halting construction at the homestead site), it did not significantly impede the long term flow of resource into household, this is so primarily because Thobela contributed so little to the household when alive. In contrast, Vuyiswa's husband remitted to the household whilst he was formally employed so the household accrued assets such as various consumer durables, and a solid homestead structure (its corrugated iron roof and cemented walls exempting Vuyiswa from the ceaseless drudgery of re-thatching and re-plastering). Post-mortem, his widow Vuyiswa derives benefit from these assets in addition to the income she receives from her husband's monthly employment 'death benefit'. In the South Africa's former homelands, resources and relative wealth often takes the form of assets and employment benefits accrued during a period of formal employment. As some of the evidence discussed earlier suggests (Yamano & Jayne, 2004), wealth may serve to cushion the impact of mortality.

Drawing on econometric analysis to understand the effects of mortality, data from South East Asia shows that the economic costs associated with death of children or elderly people are “fully compensated by the decrease of consumption units” (Grimm, 2006, p.2). In contrast, the death of prime age adults imposes the medical and funeral costs, and a net loss of income. In the case of prime age adults, this decline in household income is not fully balanced by a commensurate decline in household consumption (Grimm, 2006). Generally speaking, it is prime age adult mortality represents a net loss. However, in South Africa where many adults are both unemployed and unengaged in agrarian production, prime age adults can represent relatively weak economic units. For example, the case of Thobela is one of several where a prime age adult make little economic contribution to the household and whose subsequent death constituted no significant interruption of monetised resource flows into the household. On the contrary, Thobela’s mortality frees the household of continued expenditure on medical care (and ancillary costs such as transport). Reduced to a balance sheet of income and consumption, her death is of limited material shock to the household.

This calculus of individual contribution and consumption has to be understood within the specificity of the South Africa economic and demographic context. This includes relatively generous and widely accessed state old age grants, rendering the pension receiving elderly comparatively valuable household members in terms of their ability to secure resources. The relationship between resources and demography is evident in the manner in which receipt of a pension has the effect of ‘attracting’ additional household members who attach themselves to domestic units with resources (Klaasen & Woolard, 2005). As the state old age social grant constitutes a substantial source of income for many impoverished households, its loss upon the death of a recipient, is likely to precipitated sharp declines in household consumption. In these terms, unemployed, social-grant ineligible, uninfected prime age residents of rural locales may constitute a substantial household level fiscal burden: for they consume without providing any income. Moreover, in contrast with the (largely un-medicated and therefore terminally) AIDS-ill, the demand they make on resources is continuous and interminable. In terms of household economics, the real drain on household resources may not be the death of the AIDS-ill, but the continued residence of prime age adults unable to generate an income.

The particularities of the rural South African context see three factors: the structural context of unemployment, limited prospects of agrarian production and the exclusion of prime age adults from relatively generous levels of social protection, therefore contour vulnerability in the focal research context. A final

caveat concerning the value of prime age adults (and commensurately the effect of their loss) is appropriate. The consequences of mortality of unemployed prime age adults are here described in fiscal terms. This does not count the considerable emotional anguish and ‘social suffering’ (Das, 1997) occasioned by death. Secondly, this formulation also neglects to capture unremunerated forms of social value creation such as care work and other aspects of social reproduction. These activities are typically the providence of women, and frequently invisible to all but detailed query. Thirdly, this metric is often inattentive to the longer-term horizon, such as the interruption of intergenerational investment associated with the death of caregivers, or the adverse consequences of the disappearance of a future cohort of pension-receiving, care-dispensing grandparents. The long-term effect of prime age adult mortality may well be more weighty and significant than the short-term effects.

## **1.2 The effects of morbidity and mortality are related to the headship status of the infected household member**

The preceding section suggested how the effects of HIV/AIDS morbidity and mortality are mediated by the resources the infected individual contributes to the household. These effects are further influenced by characteristics such as the role and status of the infected individual within the household. For example, while the case studies suggested Thobela, Bongani and Nolubabalo are of limited economic value to their respective households, their liminality is further reflected in other domains. They are also peripheral in terms of the authority they command with their respective households.

Dimensions of authority and materiality are frequently co-terminus: the economic disempowerment of HIV infected prime age adults within the household undermines their authority. The structural context therefore shapes the nature of not only individual vulnerability but also the social terms it takes. The case studies attest to the decline of the institution of marriage and, along with it, the formal protections it confers. The structural context of unemployment and the changing nature of the conjugal contract alter the entitlement and claims, particularly the claims mothers can exercise against the fathers of their children. Several of the case studies illustrate the vulnerability of adult women and the limits on their claims to entitlements as a consequence of the lack of formal sanction of their unions with men. Similarly, unresourced young men are less able to engage in the material and social project of household formation. For this reason ‘headship’ and the lack of prospects for it, ought to be understood in terms of the structural context of interpersonal, social

and economic disempowerment, and as mediating the effects of mortality and morbidity.

There are a variety of positions individuals can occupy within the porous, changeable structure of the household. Accordingly, there are several ways to conceptualise a distinction between core and peripheral household members. A well-established division, pervasive in the literature on households, is the difference between formal (i.e. absent) and informal (i.e. co-resident or acting) rural household heads (Murray, 1981). An alternative, heuristically useful schema to think through status within the intra-household context is Hosegood & Timaeus's (2001) distinction between 'full' and 'affiliated' household members. Affiliated members have a more tenuous relationship to the household due to their employee status (often domestic workers or herd boys), or more distant kinship connection - it is widely understood their membership is of a partial variety. In all of these cases the relationship between household members and the household, is not solely determined by their contribution of resources, but by the status and decision making authority they exercise within it. It is here suggested the mortality of peripheral or affiliated members is likely to be less severe for the household than that of core or full members.

## **2. The effects of HIV/AIDS morbidity and mortality: Household level dimensions**

Thus far, the individual-level characteristics that mediate the effects of HIV mortality have been described in some detail. In what follows the broader household level factors that mediate or shape the responses to illness and death are considered. Although there is considerable overlap between the two domains, these are here described as qualities of household and social process. Three 'household level' mediatory factors are presented. The factors included are: firstly, household asset levels; secondly, household care and dependency ratios; and thirdly, the centrality of a household 'socio-political guarantor'.

### **2.1 Household asset levels**

Pre-illness household asset levels can be a significant factor in mediating the disparate outcomes of HIV/AIDS related illness and death. For example, the case of Vuyiswa demonstrates how the assets she is able to draw on effectively serve to cushion the shock of her husband's death; similarly, Xolile's accrued assets cushion the effects of his illness. In the case of Thobela, remittances and

the household's material base mean that her death does not significantly depress household asset levels. Households are, at least in part, constituted around resources, whether from the infected household member or from others. However, as suggested earlier in relation to the individual contribution of resources, regular *post ante* receipt of these from a terminally ill household member can exacerbate the effects of mortality, specifically if they cease with the household member's death. Deleterious outcomes are path dependent, with the initial presence of resources paradoxically magnifying the effects of their loss.

The literature suggests that negative welfare consequences are more strongly associated with the mortality of household heads, rather than with that of other categories of household member (Topouzis & du Guerny, 1999). This may well reflect the fact that the household head often brings resources into the household — or indeed that headship is frequently predicated on the ability to secure resources. The significance of assets in terms of shaping the consequences of illness and death is illustrated by manner in which receipt of two state foster grants enabled the Matibane siblings to reconstitute their household following the mortality-induced dissolution of their household.

## **2.2 Household care and dependency ratios**

A second household level factor which mediates the consequences of HIV related morbidity and mortality are household dependency ratios and care burdens. Elevated dependency ratios, following either from the illness or death of adult carers or from the in-migration of dependents in need of care can serve to adversely affect the household's ability to sustain itself. Rising dependency ratios are likely to catalyse a reconfiguring of household composition, and are particularly noticeable in cases of cumulative mortality. In the South African data, multiple mortalities are amongst the most salient predictors of household outmigration and dissolution (Hosegood et al. 2004). An example of this amongst the case studies would be the manner in which the dissolution of the Matibane household was, in part, a consequence of the cumulative deaths of the grandmother and their mother.

The importance of shifting dependency ratios and cumulative adult deaths on household composition does not necessarily negate the 'individual level' effects (highlighted in the preceding section). Adjudicating whether the deceased's or household characteristics (however, these are defined) are most significant in their effects is not the aim of this inquiry. Instead, it is suggested the

consequences of illness and mortality are forged in the space between individual vulnerabilities and household context level factors.

### **2.3. The presence of a household socio-political guarantor**

A third household level characteristic that may serve to mediate the effects of morbidity and mortality is the presence of a household socio-political guarantor. This term is used here to describe an individual who commands authority and power and who can advance household members interests, advocate for their stake and transact on their behalf outside the household. Some of these qualities accrue to individuals when they cease to be legal minors, but other aspects reflect the hierarchical, patriarchal and often gerontocratic nature of traditional rural society. This quality is hence best thought of as a continuum of influence rather than a simple binary. The workings of socio-political guarantor are graphically illustrated by the reconstitution of their household by Thembekazi's children. The three teenagers successfully secured the participation of their great-aunt in this project. Not only did her willingness to oversee the siblings help to ensure the endorsement of the extended family to the children's reoccupation of the homestead; her status as both a socially respectable matriarch and a legal adult meant she could become the designated payee of their state foster care grants. Her role and status made her essential to the children's project. The eldest of the siblings could satisfy the latter (legal adult) but not the former condition (socially appropriate dispenser of care) and could therefore himself not become the payee. This case study further demonstrates that the successive deaths of their mother and grandmother, deprived the three siblings not only of the material base of the household (primarily the grandmothers old age pension), but a social guarantor to transact on their behalf.

Similar considerations are evident in the case of Vuyiswa. In her own assessment of her position after the death of her husband, she spontaneously offered that following the funeral and return visit of the adult children 'she had not been disrespected' (fieldworker's translation). In other words her status as the legitimate, suitably bereaved and respectable widow of the deceased, meant that both her receipt of his employment death benefits and her continued right to occupy the homestead remained unchallenged. She was securely embedded in networks of entitlement, social legitimacy and protection. Her assertion that her position was secure however simultaneously invokes the spectre of the unrealised converse: a scenario of a widow whose legitimacy, fidelity or lack of responsibility for the death of their spouse, is called into question. This is a

frequent occurrence noted by Chapoto, Jayne and Mason (2007), who describe the tenorial displacement of up to a third of widows elsewhere in Africa.

The threat of a socio-political guarantor's withdrawal is to be found in the social opprobrium Bongani's relationship with Kalima elicited from both her family and members of the broader community. This suggests how moral claims to protection or support can be undermined. Kalima faced the threat of losing the favour and protection of her influential and resourced daughter, who is, effectively, her socio-political guarantor (albeit somewhat distant to the household).

## **2.4 The negotiation of stigma and illness**

A final dynamic at a household level, mediating the consequences of HIV/AIDS related morbidity and mortality is the working of stigma and denial. The tendency towards denial demonstrated by the AIDS sick can either be re-enacted or contradicted by their surviving household members (such as in the case of Thobela). Candid acknowledgement of a HIV positive status better enables engagement with prevention and treatment options (Naidoo et al. 2007), whereas denial can stand in the way of these. This duality was reflected in the previous paper (Neves, 2008), and it was suggested denial, or its absence, has consequences for how ailing household members manage their health and treatment. This may contrast with households where denial is strongly articulated and there is a larger investment in denial. This arguably positions them less firmly able to deal with illness and its consequences, particularly forms of treatment that require counselling, a 'treatment supporter' and acknowledgement of one's HIV positive status. It is partially this pre-treatment process and the efficacy of the mediation that see ARVs viewed as miraculous drugs with "recovery is often narrated as a biosocial and quasi-religious passage from 'near death' to 'new life'" (Robbins, 2005, p.7).

## **Conclusion**

In conclusion, this paper sought to consider the consequences of HIV/AIDS related morbidity and mortality amongst the small sample of rural households studied. It considered the various dimensions which mediate the effects of AIDS related morbidity and mortality, and suggested the need for a nuanced understanding of the contribution of prime age adults to the domestic economy, rather than the perhaps more intuitive assumption that their loss of prime age

adults represents an inevitable, immediate or homogenous shock. Essentially households respond to shocks in a variety of different ways, which can be attributed to both the qualities of the deceased and household level factors more generally. It was suggested that the material resources affected individuals are able to access and their status within the household are salient individual level characteristics. Communal level qualities, mediating the consequences of HIV/AIDS, include household asset levels, care and dependency ratios, the presence of a socio-political guarantor, and finally the manner in which stigma and illness are negotiated.

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