

**The role of social fluidity and mobility in household responses to HIV and AIDS
in rural KwaZulu-Natal, South Africa.**

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Introduction

Writing in 1993, Maxine Ankrah (1993) suggested that HIV and AIDS-related illness and death would affect the ability of the African family both nuclear and extended to respond, to the needs of those affected. Ankrah (1993) goes on to suggest that in undermining these family coping strategies, the impact of illness and death may result in the development of new social associations and networks of sick people outside of the family and unrelated to kin, but rather linked through common experience (Ankrah, 1993). Part of this argument is that the family and household are becoming increasingly nuclear and therefore the obligation to support and care for members of the extended family are being reduced and ultimately lost (Ankrah, 1993).

The literature relating to the household and family in South Africa suggests that despite changes to the structure of the household, the household is not becoming nuclear (Russell, 2003a, Ziehl, 2002, Russell, 2003b, Russell, 2004a, Spiegel, 1996). Rather the fluid or stretched nature of the household is increasingly accepted as a result of widespread circular migration. Such patterns of migration between rural and urban areas have been observed in South Africa for much of the last century (Hobart Houghton, 1974). The circular nature of migration was entrenched as a result of the physical and geographical divisions between race groups created by the Nationalist and Apartheid governments since 1913 (Hobart Houghton, 1974, Russell, 2004a). Despite assumptions that these patterns of individual rural-urban migration would change at the end of Apartheid, they continue to this day with high levels of adult migration from rural to urban amongst equal numbers of women and men (Posel, 2003).

The household and its formation in South Africa reflect these patterns of migration and are therefore not easily defined. A number of empirical studies of black households in South Africa, both qualitative and quantitative suggest that a broad definition of the household is required for meaningful analysis of the household and its components, taking into account the complex social, economic and political factors which have changed the lives of black South Africans (Spiegel, 1986, Lundberg et al., 2000, Ross, 1996, Wittenberg and Collinson,

2007, Hosegood and Timæus, 2006). This definition recognises the membership of people both resident and non-resident in the household, that there is very regular movement of people into and out of the household and that the household includes members with multiple household memberships (Hosegood and Timæus, 2006, Ross, 1996, Spiegel, 1986, Spiegel, 1996). The South African literature also highlights the importance of kin in the formation of, and relationships within and between, households. The importance of kin persists despite socio-economic pressures and changes to the relationships between extended family. Kin is also associated with norms of obligation which exist between members, both resident and non-resident within the same household (Russell, 2004a, Amoateng, 2004, Hosegood and Timæus, 2006, Spiegel, 1996, Russell, 2003b, Viljoen, 1994, Wittenberg and Collinson, 2007).

Such obligations within the extended family, fluid and stretched households are important for households that experience HIV and AIDS-related illness and death in South Africa. The obligations are governed by norms and values which determine whether household members who are sick are supported and cared for and by whom. The province of KwaZulu-Natal has the highest prevalence of HIV and AIDS in South Africa, estimated at 37.4% in 2007 (Department of Health, 2008). In the study of Umkhanyakude in the rural north-east of the province HIV prevalence amongst non-resident members exceeds that of resident members. In 2003/2004 the HIV prevalence among non-resident adult women aged 15-49 was 41%, while it was 27% in resident women. Prevalence was 34% in non-resident adult men and 14% in resident men aged 15-54 (Welz et al., 2007). Patterns of high non-resident HIV prevalence coupled with patterns of circular or return migration have the potential for affecting relationships between non-resident sick household members and their rural households.

The empirical evidence from a number of longitudinal quantitative studies in Umkhanyakude and Agincourt in South Africa suggest that an increasing number of people who previously migrated from rural areas return to these rural areas when they become ill (Clark et al., 2007, Welaga et al., 2009). In both settings the returning migrants were found to be more likely to die than residents (Clark et al., 2007, Welaga et al., 2009). Booyesen

(2006) also observed a pattern of migration after diagnosis of HIV-status in a study in the Free State Province.

Despite free access to ART in South Africa, strict eligibility requirements which require treatment initiation at an advanced stage of illness and a habit of late presentation for treatment means that many infected adults are very sick by the time they start treatment (April et al., 2009, Coetzee et al., 2004, Lawn et al., 2006). The progression of illness results in many of those who are employed eventually losing their jobs, due to the severity of their illness (Barnett et al., 2001, Russell, 2004b). These factors combined mean that despite improved access to treatment, with positive health and quality of life outcomes in the long run, there is still a large burden of sick adults. These adults, who at some point before and even after treatment are very sick, require care and support and are possibly unemployed or unable to earn income to support themselves, even if this is just in the short-term (Coetzee et al., 2004, Barnett et al., 2001, Russell, 2004b, Clark, 2006, Saith, 2001).

The presence of a sick person within the household has been shown to have a number of impacts on South African households, specifically demographic and economic (Booyesen, 2004, Booyesen and Arntz, 2003, Booyesen et al., 2002). This paper will not focus on these. It will explore the motivations and obligations, which determine how family and household members provide care and support to sick previously non-resident members. Evidence exists that the obligations and expectations inherent in kin relationships still play an important role in the livelihoods of rural South African households (Belsey, 2005, Everatt et al., 2005, Haddad and Mallucio, 2002, Russell, 2003b, Sagner and Mtati, 2000). The idea of a family obligation dictated by normative rules within society (Finch, 1987). The importance of this sort of moral obligation to family in South Africa has been acknowledged by Ross (1996), Sagner and Mtati (2000) and Bozalek (1999) as an important motivating factor in various forms of support and care within household and family.

This paper investigates the way that fluid membership of South African households and high residential mobility influences non-resident household members' access to support and care in the context of HIV and AIDS-related illness. It explores the relationships between non-

resident members and their rural households prior to illness and the way in which these relationships change during illness and once the sick people migrate home to the rural household. The obligations and motivations that determine the support and assistance provided to these previously non-resident household members and their children during illness and in some cases after death by members of the rural household and family are then investigated.

Methodology

Sampling and data collection

The study enrolled 10 households reflecting as far as possible the range of households in the area. Households were chosen either because they had experienced the death of an adult from AIDS-related complications or because they currently had an adult household member who was living with HIV or AIDS. The study results are restricted by the fact that they represent a rural perspective

Three households were recruited from an existing selection of households within the district that were originally part of an ethnographic study conducted at the Africa Centre for Health and Population Studies between 2002 and 2004 (Montgomery et al., 2006, Hosegood et al., 2007). The ethnographic study sample included 20 households. At the beginning of the aforementioned study in 2002, each household possessed a member exhibiting the symptoms of TB or AIDS. Households in the original study were recruited through volunteer home-based care workers, Africa Centre verbal autopsy nurses and through other opportunistic contacts (Hosegood et al., 2007). Extensive translated fieldnotes and genograms from the original study, based on the household's experiences, assisted in narrowing the choice of households to visit. These three households are of particular importance in exploring how contemporary responses to illness and death are influenced by the household's historical experiences.

Five further households, with at least one member sick and or on treatment, were recruited with the assistance of the Home-based Care program (Unkhulunkulu Nathi), operating out of the local Catholic Church. The inclusion of households with a sick member was important because it afforded an insight into various households' experiences of illness and the period preceding death. In planning, the aim was to interview a range of adult household members including those living with HIV and AIDS (PLWHA) and those receiving antiretroviral therapy.

One household that had experienced an adult death suspected to be AIDS-related before June 2007 (six months before the beginning of data collection) from within the Hlabisa sub-district, identified by the Africa Centre verbal autopsy nurses was also included. A further household was also chosen through an opportunistic contact with the core respondent.

Table 1 shows the household characteristics classified according to household typologies developed by Wittenberg and Collinson (2007). The households within the sample all included non-resident members at some point in the study period. The sample reflected a range of household incomes. All the households received at least one social grant in the six months we were visiting them. The sample included households with members working in the formal sector, households with no members formally employed, and households from deep rural, rural but accessible, and peri-urban areas.

Data were collected using a number of different qualitative methods with the aim of developing in-depth case studies of each household, their situation and experiences. Methods included in-depth interviews, open-ended structured interviews with each household and non-participant observation. The data collection in each household involved at least 5 formal interviews and a number of other informal household visits. Each formal interview had a different topic focus. The decision to use a range of research methods was intentional, to increase the variation in types of information collected and to construct a multi-layered story of the household and its experience.

The first interview in each household involved the collection of detailed information about the household, its membership and the demographic details of the resident and non-

resident members, including people who had died within the preceding 5 years. These were collated and a genogram was generated. An updated version of the genogram was also created to reflect the household's situation at the final visit.

Table 1: Basic Household Characteristics

Household	Household Sampling	Head of Household	Type of Household*	HIV/AIDS-related event
Ntuli	Home Based Care Worker	Female	Three generations	Death and Illness
Nkosi	Home Based Care Worker	Male	Nuclear	Illness
Mabena	Home Based Care Worker	Female	Three generations	Death and Illness
Sibaya	Home Based Care Worker	Male	Nuclear (adult children)	Illness
Bhengu	Home Based Care Worker	Female	Three generations	Illness
Zondi	Ethnographic Study	Male**	Sibling household	Death
Dube	Opportunistic Contact	Female	Three generations	Illness
Dlamini	Verbal Autopsy Nurse	Female	Multi-generational	Death and illness
Shabalala	Ethnographic Study	Male	Complex related	Death
Gumede	Ethnographic Study	Male	Three generations	Death

*(Wittenberg and Collinson, 2007)

** Female non-resident head.

The second interview involved the creation of a Household Event Map of the important events and episodes the household identified within the 5 years preceding the study. Along with the production of the household genogram and household event map, there were also a number of in-depth open-ended interviews.

The in-depth interviews were organised with the use of a topic guide but also included themes emerging from the earlier interviews. Non-participant observation was another important data collection method that the study employed during interview visits but also during informal household visits which were conducted at least every two weeks. Therefore

the study was able not only to collect retrospective data but also rich prospective data about the day-to-day lives of the respondents and their experiences.

Ethics

Ethical approval for the study was granted by the University of KwaZulu-Natal Humanities and Social Sciences Research Ethics committee and the London School of Hygiene and Tropical Medicine Research Ethics Committee. All household members being interviewed were required to sign a form consenting to being interviewed.

Households linked to the home-based care program already had some level of prior disclosure of the sick person's HIV status to outsiders. In all of the households, regardless of our prior knowledge about status, at no point was anyone asked about the cause of an illness or death unless households raised the issue themselves, which they invariably did. Despite difficulties in discussing the precise causes of illness and death, this reality did not seem to limit people's willingness to talk about the consequences of these episodes and events or of other factors surrounding them which were of importance to the study.

Analysis

The use of more than one method of data collection facilitated the use a range of methods of data analysis and interpretation. The data were used to develop household case studies, which were examined both independently and in comparison with other cases. The household genograms and household event maps constructed during the collection of the data were also considered part of the analysis and interpretation of the data. To further develop themes about intra and inter-household relationships, social network maps were created for each household showing flows of support, resources and financial assistance. The interviews were recorded, transcribed and translated at the same time as data collection so key themes could be further explored in follow-up interviews. Fieldnotes and memos provide a written record of interviews and non-participant observation. The

transcripts, fieldnotes and memos were also cross-sectionally coded using an iterative process which involved building upon and refining an initial framework of codes.

Results

The residential core household functioned as an important safety net for sick returning non-resident adult household members who needed to be taken care of. Five households in the study had a sick newly resident adult member whose illness required care and financial support. Such previously non-resident members were a severe burden on the households' already limited financial and human resources. The inability of sick people to work and their physical and medical needs increased this burden. Despite this the sick person was able to rely on their rural household to provide at least a place for them to stay. Families also provided a range of other services, such as physical care and financial support. The support depended not only on the availability of resources and household members to provide care but also on the level of motivation or obligation which the family or household members felt to provide the said care and support. The quality of the relationship between household members was also very important and as were the ties that non-resident household members maintained with the rural family.

Close family ties despite distance

Prior to their illness, most of the non-resident household members who became sick, maintained close ties with their rural households, families and particular individuals within the household. The households of three of the non-resident members gave examples of these links within the interviews. Zinhle Bhengu and Senzo Gumede both had children who were living in their respective rural homes and being cared for by their children's grandmothers. Zinhle and Senzo were living and working in St. Lucia and Durban respectively, but retained close contact with their rural households, their children and their mother's who were their children's primary caregivers.

Along with Lindiwe Mabena, who was another non-resident household member, they visited their rural households when they could, sent money home and brought groceries for the household when they visited in order to maintain their relationships with the household and with certain family members in particular. Zinhle and Senzo also sent support for their children who were resident in the household.

During an interview Zinhle's mother, Nomsa spoke about the change in the household situation since Zinhle has become ill and could no longer contribute to the household.

[Zinhle] was the man [of the house], there were deliveries to the house before she was sick but now there is nothing. Look at that building, [Zinhle] was the one who was building that house.

Nomsa Bhengu, female household head, 56 years

This quote highlights the close ties Zinhle maintained with her household before her illness. Nomsa felt that the situation in the household had changed a lot since Zinhle had become ill and that the household was substantially worse off now that Zinhle was no longer contributing to it. This was also the consensus in the Mabena and Gumede where the change in the non-resident household member's work and life situation had a substantial influence on the household, mostly through the loss of remittances and support for the household provided by the non-resident household member.

Zinhle had been building a structure at the homestead that the family would have been able to use it as was the case in other households within the study. Zinhle would have also been able to use the structure when she returned to the household but she fell ill in the middle of construction and the building was not completed. Lindiwe had helped to pay for an extension to her mother's home and also for the roof to be repaired. These repairs made a big difference to the quality of life for Lindiwe's family and meant that she had a room in the house when she became ill. This important contribution to the rural household ensured that the non-resident member had claims to a part of the rural homestead.

Familial bonds and close relationships were also important, such as in the case of Simphiwe Ntuli. Despite being married and living in a nearby township with her husband and young son, Simphiwe maintained a very close relationship with her mother and siblings in her

maternal home. She attended church with her mother and visited often so that when she fell ill, her mother moved to her household to care for her. Later both Simphiwe and her baby returned to her mother's home to be cared for. Before Simphiwe died she made a special request for her younger twin brothers to care for her son.

Although there were examples within certain households of support provided by siblings for both the sick non-resident household members and their children, the most important relationship non-resident household members had was with a parent. In most cases this was with their mother who was the household head in half of the study households. The importance of these parental-child relationships for the non-resident household member and the special obligations associated with these relationships will be explored in the following sections.

The fact that migrants maintained close ties with their rural household during periods when they were not resident had implications not only for the household but also for the non-resident household member. The rural household was an important source of support for the migrant in times of crisis specifically in the context of HIV and AIDS when the non-resident member was ill. In many cases the non-resident members, who migrated back to their rural household when they became ill, came because they were in not fully established in the urban or peri-urban areas and did not have the family or social network to care for them or provide financial support.

Rural household and family as source of greatest support and care

It seems that the care and support the sick non-resident household members needed was hard for people to get where they were living in urban and peri-urban areas. The pastor from Zinhle Bhengu's church in town brought her back to her mother's home when she became ill, as there was no-one to care for her in the town. Senzo Gumede's mother spoke about being told that her son was sick and getting a vehicle to drive from Umkhanyakude the two and a half hours to Durban to pick him up. Even though these people had friends in the urban area, the relationship did not seem to stretch to care and it was Senzo's friends

with whom he had been living that contacted his family to come and fetch him when he became very ill.

Zinhle, unlike Lindiwe and Senzo, was in a relationship, but she was not married and didn't live with her partner. Although her partner did provide some financial support for her to access treatment, the lack of formal relationship with her partner's household meant that her mother's household was the place where she returned when she became ill. The rural household and family were the people who non-residents had close relationships with and could rely on to help them in times of need.

The family and rural household is a source of support in other times of crisis or stress, unrelated to illness. Such support was observed in Tina Ntuli's household. Her non-resident son lost his job in town, thereafter he returned to the home of his mother where he was reliant on her for food and financial support, until he was able to get a job. One of Nomsa Bhengu's daughters also returned to her mother's home for a short while after she separated from her husband until she was able to get into a course of study in a nearby town to study nursing. Therefore for those non-resident members of rural households who had migrated to urban or peri-urban areas, the household and family were an important safety net during periods of difficulty in their lives.

Households and families provided support and care to sick previously non-resident household members in a number of ways. Care has been defined by respondents in a study of caring in black South African households both in physical and in economic terms (Bozalek, 1999). Physical care for sick adults within the household was mostly provided by female members of the household. In four of the household's the primary carer of the sick person was their mother, who was also either the household head or wife of the household head. Mothers were supported in caring activities by the siblings of the sick person, both brothers and sisters, and in one case the partner of a sibling. Such care included help to prepare food, look after children, wash clothes and help the sick person get to the toilet and the clinic. Sick household members also needed to be reminded and supported to take their treatment.

All of the sick, newly resident household members had lost their previous employment or ability to earn an income when they became sick and were therefore not able to support themselves financially. Financial support enabled physical access to the clinic for regular checkups, treatment and to social welfare for social grants. Lindiwe Bhengu was an example of this. She was required to attend daily appointments at the clinic to get her tuberculosis medication. Sick household members also need to be fed and clothed. The households were often already struggling to survive. Only one of the five households with a sick member who had returned had a person who was employed and the household's were therefore mostly reliant on income from social grants.

Not only did the household need to absorb the costs associated with access to health care and treatment, they had the physical barriers to transport caused by illness to deal with. They either required special transport or someone to go with them in order to ensure they were able to complete this journey. This was not only expensive but difficult. Nomsa reported the difficulties that she and her household confronted while trying to help her sick daughter Zinhle access treatment and healthcare at the clinic.

[Zinhle] can't walk, I don't have money. Where can I get the money to go to the clinic everyday? [Zinhle] can't walk she falls down and [there are times] I have failed to take her to the clinic...[Zinhle] went together with my youngest daughter. They had to take a taxi, there is nothing else they can do. I borrowed the money [for it]. I don't know what we will do tomorrow. [Zinhle] will have to go alone.

Nomsa Bhengu, female household head, 56 years

The sick household members also required food and sometimes this was difficult for the rural household to provide because of shortages of money and the other needs of the household.

We don't have bread. [Zinhle] was going to the clinic. She was crying that she was hungry while she was at the bus stop.

Nomsa Bhengu, female household head, 56 years

The rural households therefore confronted difficulties in providing the sick previously non-resident household members with care and support. This was particularly marked in the cases where these individuals were unable to or had difficulty accessing the disability grant, a government cash transfer, for which people who are sick and deemed unable to work through a medical assessment are eligible.

Another very important source of support that the rural household and family, in most cases the mother of the sick non-resident household member provided was caring for the children of the non-resident household member. Four out of five of the household's that cared for a non-resident sick household member also cared for the children of these people. These children were absorbed into the household and looked after communally in the most part but in all the cases in the study the primary caregiver of the children was the mother of the sick person.

Motivations and obligations to provide support and care

The rural family and household were the most important source of support for the sick, previously non-resident household members despite the difficulties that the households confronted in providing this care and support. A number of factors influenced and motivated the support that these individuals received.

One of the strongest motivating factors for support was the familial relationship and bond which existed between people before the illness. Tina Ntuli, whose daughter became sick while living with her husband and child in a township near her mother's home, spoke about her responsibility to her daughter.

[Simphiwe] was sick, I went to stay with her [at her husband's house]. When I decided to come back she asked the church elders whether she could come back to my house, because she was sick and had no-one to take care of her, even though she was supposed to stay because she was a minister's wife. They allowed her to come home...

Tina Ntuli, female household head, 63 years

As is the case with Tina and her daughter Simphiwe, the closest and most important relationship was most often between children and their mother who felt the greatest obligation to care for their children.

The bonds and strong obligation to children versus other kin is demonstrated in the Mabena household where there were a number of sick household members. These included Lindiwe, the household head Nobantu's daughter and two of Nobantu's brothers. Nobantu's motivation and dedication to caring and support was observably different for her daughter and brothers. Nobantu provided support and care to her brothers; lunch every day, help

with washing and giving them their medication. This was different to the care and support she was observed providing for her daughter. The support and care Nobantu gave to Lindiwe was much more involved and attentive. Lindiwe attended the hospital and the clinic much more regularly than her uncles, paid for by her mother. She lived in her mother's house, while her uncles lived in an outhouse on the same property. This outhouse was visibly ill-equipped, one room used for sleeping was only half covered and was one third open to the elements. Nobantu was more distressed about Lindiwe's condition and was more actively concerned with her care.

Nobantu's decision to support her brothers seemed to be dominated in part by their extreme need but also by a moral obligation to kin indicated in Nobantu's response when asked who cared for the sick men in the household: "They are my brothers, they have no-one else". Despite this the level of support and obligation she felt for her own daughter was greater.

Nobantu's motivation and obligation to help her children was demonstrated in a statement she made while discussing her efforts to pay school fees and buy clothes for her other children, both at the time of the interview (she had one child still in high school) and in the past.

There is nothing else for me to do [other than help] or my children will grow up and kill me if they think that I was not helping them.

Nobantu Mabena, Female Household Head, 65 years

This statement is very telling. Although Nobantu does not mean that her children will literally kill her, she is referring to the fact that they will not look after her later on when she is no longer able to take responsibility for the household and its members, and when she herself needs to be cared for. One motivation to care for and support her children is the hope that they will care for her in the future.

All the returning non-resident household members also had children. In two cases the children were already resident but in three of the households the children returned with their parents increasing the pressure on limited human and financial household resources.

These children were absorbed into the household. Tina Ntuli related her feelings about caring for her grandchild.

I don't have any problem with [caring for her grandson] because I know that he is my child's so he is mine too.

Tina Ntuli, female household head, 63 years

This statement shows the obligation respondents in the study felt towards family, particularly close family, who they voluntarily provided support and care for.

The Sibaya household had a situation which was slightly different to the situation in the other households where someone returned home when they were ill. Mandla was very ill when he returned home and, although he was resident on the property and fed with the family, he operated quite independently in other ways from the household and family. Mandla had not maintained a very close relationship with this household and, although his step mother, Precious, did cook for him, she did so grudgingly and expressed on more than one occasion her dissatisfaction with the situation.

Mandla doesn't give us anything. He keeps his money [from Disability Grant] in his pocket...We don't know how he spends his money, he doesn't even help us to buy food...Mandla and Blessing are just supported, here at home, by their father. Neither of them buys food. Their father buys the food...and me, I also buy [food] with the money from the child support social grant.

Precious Sibaya, wife of household head, 36 years

Precious, was particularly unhappy because of Mandla's lack of contribution to the household both before and after illness forced him to his return to his father's home, despite his accessing a disability grant. Precious was highly critical of what she perceived as Mandla's spending on wasteful extravagances instead of contributing to the household. This possibly suggests that although family or moral obligation to support and care for family members is strong, there is also an element of expectation for previously non-resident household members to provide support where possible.

Discussion

In South Africa the stretched and fluid nature of household and family composition means that the family and household are very important even for people who have migrated and are separated from the household, sometimes by long distances. The evidence within this study

and other studies which explore the stretched and fluid nature of household suggests that non-resident members maintain strong ties to their rural household and the family (Murray, 1980, Posel, 2001, Russell, 2004a, Spiegel, 1986, Spiegel, 1996). These results suggest that despite some assertions to the contrary, the South African family does not seem to be nucleating. Rather the household is fluid and made up of multiple generations of family including resident and non-resident members.

Household members may migrate elsewhere, for work or other reasons, for very long periods of time and either establish new households or become part of existing households. Nevertheless these adults still maintain close ties with their rural households. These ties may be purely social and involve no financial or physical support. The ties are not always formal and consistent, such as regular remittances. For example some non-resident household members had children who were resident in the rural household and cared for there. They also sent money home, sometimes regularly and in other cases intermittently or in times of specific need within the household such as for a funeral. Others supported building projects in the rural household.

The fact that non-resident household members maintained close links with their rural household and family meant that in many cases the rural household and family were the greatest source of support for non-resident household members in times of need and crisis. The relationship between household members both resident and non-resident is particularly important in light of the effects of HIV and AIDS, especially within the study community where prevalence in the non-resident adult population was over 30% in 2003/2004 (Welz et al., 2007). Evidence of patterns of return migration of these adults as they become increasingly sick and after their diagnosis has been observed in the study area and in other rural areas within South Africa (Clark et al., 2007, Welaga et al., 2009, Booysen, 2006).

When these non-resident household members became sick the household and its members provided a wide range of support for the sick returning household member including physical care, financial and emotional support. This was especially important for the sick adults such as those captured within this study, who had limited social and support

networks without easy access to their rural families. The provision of support and care also had implications for the household, specifically its economic situation. This has been studied in-depth elsewhere with respect to resident members who become sick in the household (Barnett et al., 2001, Russell, 2004b, Clark, 2006, Saith, 2001, Booysen and Van der Berg, 2005).

The results also suggest that the presence of these strong intra-household familial ties, which can be either purely familial or social and may include financial and physical support, are linked to the obligation, rural households and family members, have to support and care for their non-resident household members when they become ill. The obligations may be purely moral and due to familial links governed by culturally and socially constructed norms and obligations to family members as suggested by other South African studies about intra-household support and care (Sagner and Mtati, 2000, 1999 #428, Bozalek, 1999). These moral obligations seem to be linked to the quality of relationships between non-resident and resident household members and are also often linked to close familial relationships such as parent-child or filial relationships.

Rural households and family members were also influenced by norms of reciprocity. Reciprocal obligations were associated with the support that the household had received in the past from the non-resident household members. A further dimension was that the household and its members, specifically the older household members, parents or grandparents who were most often the primary caregiver for sick adults and their children, saw the sick adults as a form of social insurance. The sick adults, if they became well again, might have been able to support the household or certain individuals in the household. Similar findings were made in a study about the pooling of the Old Age Pension in South African households (Sagner and Mtati, 2000). The Sibaya household provide an example of the expectation that households have that non-resident members contribute to the rural household where possible and the implications that this has for their support and care. Therefore there may be some future expectation attached to the support that people provide. The close physical and financial ties the non-resident household members maintained with the rural household and its members may be another form of social insurance, for the care

and support of their resident children within the household or for themselves in times of need or crisis.

Households within the study did receive external support from within a wider community and social network. Respondents in the study suggested that, unlike in the past, the burden of illness, death and general poverty borne by the community as a whole meant that the ability to provide substantive physical or financial support was limited. The intra-household social networks were therefore perceived as very important. The stretching of households across different locations fostered by fluid household boundaries, as well as the presence of supportive relationships between resident and non-resident household members are not new strategies. There are historical patterns within rural South Africa of the importance of these intra-household relationships. These are observed in other times of crisis and in patterns of child fostering, circular migration and the maintenance of relationships between rural households and urban non-resident household members. The evidence here suggests that these patterns are still important in the context of HIV and AIDS among non-resident household members. This has come about despite the widespread impacts of HIV and AIDS-related illness and death, social, economic and political changes that South Africa has experienced over the last two decades.

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