Migration and HIV/AIDS in Rural South Africa: A dual-phase intergenerational, gendered chain migration

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Abstract

Migration is a complex process that is fundamental in understanding the complexity of societies across the world. In South Africa, there are high levels of migration associated with HIV and AIDS, and the process is intrinsically linked with issues associated with population health. Research conducted in KwaZulu-Natal Province, and in the wider country, has reported on a circular migratory flow of women to and from the province. However, this paper presents findings suggesting that the gendered migration occurring in this area is actually an intergenerational process of chain migration that involves women of different generations moving to South Africa from households in other southern African countries. Younger women are initially motivated to move by various push and pull factors, such as economic or environmental instability. Despite enthusiasm to move and motivation to succeed in South Africa, their experiences of migration to South Africa are mostly characterised by negativity. Often exposed to unsafe conditions coupled with a lack of opportunities for meaningful work, many are left vulnerable to HIV contraction. Older women then migrate to follow their daughters in response to requests for support, forming the second phase of this process of intergenerational chain migration. As a result of this process, which is strongly influenced by HIV, there are emerging communities of younger women who require access to services for HIV, and older women who are in need of primary care services associated with ageing while they are providing assistance to their kin and new host communities.

Keywords Migration, HIV, AIDS, South Africa, Health, Gender, Women, Southern Africa.

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Background and Review of Literature

Migration refers to the flow of people between and within regions and countries that takes place globally (Haour-Knipe, 2009). Migration can occur between as well as within regions and countries, as people from different backgrounds, generations and origins migrate in response to a range of push and pull factors. These factors can include forced displacement owing to conflict or famine, physical or economic insecurity and historical migration patterns. However, this paper is concerned with an emerging pattern of interregional migration. Interregional migration refers to the movement of people between countries, but within a geographical region. In this case, the region is sub-Saharan Africa. Interregional migrants often hold the view, and the hope, that the new host country will provide improved living conditions, such as security, migrant community engagement and opportunities for employment (Kok, 2006).

Migration is particularly evident throughout South Africa (Camlin et al, 2014) and has been influenced by the socio-political context of the Apartheid era. During Apartheid, historically disadvantaged, black South African men were systematically located to areas where labour was needed in order to reinforce the historically advantaged position of white South Africans (Posel, 2010). During this period, government policy sought to prevent the movement of black South African women away from rural areas (Ngcobo, 1990). This containment of women in rural areas sought to reinforce the control the Apartheid government had over the movement of black South Africans. Despite these movement restrictions, women have been successfully migrating to, from and within South Africa since the early 19th century, mostly as migratory leaders, in search of income-generating opportunities (IOM, 2010). Furthermore, Neves and Du Toit (2008) understand that the current structure and dynamics of households in South Africa can be attributed to these historical-political migratory movements.

The gendered nature of South African migration is increasingly being recognised and a number of studies have identified that migration in South Africa is disproportionately becoming feminised: it is a process that women participate in. Muhwava and colleagues (2010) reported increasing numbers of women participating in migration in KwaZulu-Natal Province (KZN), whilst Collinson et al (2006) identified that women aged 15-25 years are the most mobile population category in the country.

The migration dynamics within KZN, particularly, are a pertinent issue that have the potential to impact social cohesion, service provision and demography in the province. KZN is easily accessible for African regional migrants as it is located in close proximity to international borders with Mozambique and Swaziland. The province also has a number of large scale farming areas and popular tourist destinations that are perceived to offer employment opportunities. These factors, when combined with the lifting of restrictions on the movement of black Africans since the end of Apartheid in 1994, have meant that large numbers of economically active people of working age and ability have migrated to rural farming areas in KZN in search of employment in agriculture and tourism.

Migration in KwaZulu-Natal Province has been described as increasingly gendered (Camlin et al, 2014), and has been reported as such in research from the Northern Coastal Region of KwaZulu-Natal Province (Camlin et al, 2014; Bennett et al, 2014). Using data from the Africa Centre Demographic Surveillance Site (DSS), Camlin and colleagues (2014) report that 50.4% of women, as opposed to 35.3% of men, participated in migration to rural areas between 2001 and 2006. Similarly, Bennett and colleagues (2014) identified increasing mobility of women, particularly parents. Research from the Africa Centre DSS that documents the "extraordinarily high levels of mobility" of adults on the north coast of KwaZulu-Natal, also claims that these high levels and increasingly gendered migratory patterns are cyclical or circular, consisting mainly of local, rural-to-rural migratory movements of predominantly black South African women (Camlin et al, 2014). The authors found in 2001 that participants in migration of this sort were predominantly female (108 per 1000 female, as opposed to 86 per 1000 male) aged 2-24 years, with black South African women seen as participating more than men in a local short-term circulatory migratory flow, and predominating in a rural-to-rural flow of people.

In contrast, the findings presented in this paper suggest that the gendered migration occurring in these northern, coastal rural areas of KwaZulu-Natal involves a more complex flow of women. Women participate in an intergenerational process of chain migration, whereby older women move as migratory followers of younger women from their original households. These households of origin are most likely located in other Southern African countries, meaning that migration is interregional. The women leave in response to push and pull factors. One of these is HIV, which has been long

identified as being a major source of household instability, particularly in northern KwaZulu-Natal (Hosegood, 2009).

HIV has for three generations been the major public health challenge faced by South Africa. There are an estimated 7,000,000 people living with HIV in South Africa (UNAIDS, 2015), with the most vulnerable demographic sector being young women and girls aged 10-24 (UNAIDS and The African Union 2015). KwaZulu-Natal Province is disproportionally affected by the HIV pandemic, and has the highest proportion of people living with HIV in the country (28% of all adults) (HSRC, 2014).

As such, it is not surprising that HIV has been identified as an agent promoting the movement of household members to and from KwaZulu-Natal Province, especially women and children (Hosegood et al, 2004; Hosegood et al, 2007). However, the movement of people discussed in the studies above relates mainly to vulnerable, black *South African* women of reproductive age and not, as argued in this paper, different generations of migrant women originating from the same households from across the *Southern African* region.

This paper presents findings from fieldwork conducted in 2011 and 2012 in a rural location in KwaZulu-Natal Province that describe the migratory flow of women to this Northern Coastal area of the province. The findings indicate that there is a newly emerging intergenerational movement of women, which is different from previously identified patterns of migration. It is argued that the findings are relevant to the development of policy related to the provision of primary health services for women in rural areas of South Africa.

Methodology

Data collection took place in 2011 and 2012 in one large community comprising four village areas on the north coast of KwaZulu-Natal Province. The community, villages and participants are all anonymised. The research methods used during the ethnographic fieldwork were: non-participant observation and semi-structured interviews with younger women (30 years and younger) and older women (31 years and older). A basic community mapping exercise was also incorporated into the fieldwork.

Through non-participant observation, the researcher was able to become familiar with the different places and spaces, and was able to meet members of different social and community groups, as well as potential host organisations for accessing large numbers of the population of the villages. The researcher spent time observing popular places within the community,

talking to local people and making notes. Initially the researcher was based at a crèche and community project, which was selected as it was located in the centre of the commercial area and was easily accessible. However, as informal discussion with participants identified additional hubs less visible to an outsider, these were included in the sampled sites for non-participation observation too. These hubs included a central trading store that sold alcohol and groceries, where hawkers and informal traders gathered at month-end to sell home-grown vegetables and second hand clothing. The researcher was also directed to an '*uwashe*' which is an easily accessible area of the river, where women meet to wash clothes and chat, as well as other crèches located around the village areas. These crèches were mostly run by older women, *gogos* (grandmothers). Some time was also spent in *shebeens* (taverns without liquor licenses), talking to men and learning about gender relations in the community areas.

This non-participant observation facilitated the development of not only an understanding of the local socio-cultural context, but also the extent of the complex socio-spatial relationships between ethnicity, origin, migratory status and location, as people who originated from different countries in Southern Africa and other South African regions generally lived in different village.

Meeting people, women in particular, and engaging in informal conversation led to the identification of participants for the semi-structured interviews. Additional participants were identified using a snowball sampling method, which led to the final interview sample size of 64 women and 8 men. Men were included in some family group interviews, but not interviewed individually. All participants were provided with information sheets in the predominant local language, isiZulu, and gave their verbal informed consent before participation in the study. Whilst all participants were given the option to refuse to participate or to withdraw at any point without penalty, there were no refusals. Dr Alexandra Plowright conducted semi-structured interviews about women's experiences of migration, or migrants living in their communities. Some participants were interviewed not only individually, but also with their peers or families in natural group interviews. Women of all ages were included in the sample, with the only selection criteria being their willingness to participate. Men were not excluded from the sample, but were not actively sought. Therefore, the only men included in the sample were those who were present at the time of interviews with (a) female participant(s), where they chose to contribute to the discussion.

The interviews were conducted in a combination of isiZulu, SiSwati, English and uChope, depending on the language of the participant, and all interviews took place in a location of the participants' choosing.

Interview participants discussed their own experiences of migration, which were strongly rooted in their backgrounds: older migrant women spoke in depth about their own experiences and, their understandings of the experiences of others. Local, South African women of all ages were enthusiastic and eager to talk about their lives and experiences. During individual interviews women divulged personal information, and discussed sensitive topics, such as their views on the HIV pandemic, attitudes of others and sometimes their own HIV status. Group interviews were usually conducted later, either in peer or family groups. Peer groups provided a platform whereby women of similar ages could discuss issues pertinent to their generation, whereas family groups sometimes included men and, as such, provided insight into the gender dynamics within the household as well as socio-cultural norms within the village.

Selected women from different generations were invited to participate in a basic, modified participatory mapping exercise. Participants involved in this were those whose interviews referred to and relied heavily on visual representations of their village. The mapping exercise involved the participant and the researcher walking together through the village with a very basic map, containing a diagram of the river, the two main roads and a cross that indicated the starting location (usually the woman's home). As the journey progressed, the participant identified the places of interest to them and marked them on the map. This methodology lead to the telling of detailed, complex stories about their lives in the local area, their experiences, their feelings and their personal history and links with the community and the village where they lived. Data were analysed thematically by Dr Alexandra Plowright using NVivo 9 software. The analysis was inductive, and data from different sources were triangulated to ensure rigour.

Results and discussion

Results from this research have demonstrated that migration to the study area located on the north coast of KwaZulu-Natal Province has led to the gradual development of a visually segregated space, divided into village areas that are distinguished according to the migratory origin of residents.

At first glance, the area seemed to be a generic, typically South African, isiZulu-speaking community that was small in size. However, the true extent of diversity was revealed through both observation and interviews with residents from different backgrounds: the larger community area was segregated and segmented. Specific spaces had developed for non-migrants and others for migrants. The latter included South African internal migrants and international migrants who were mostly from Mozambique, Zimbabwe and Swaziland.

The wider area was clearly divided into four highly distinct sections, with characteristics that set them apart as separate villages. These different village areas are referred to as villages A, B, C and D. Village A comprised of low-cost housing built as part of the government's Reconstruction and Development Programme (RDP) which focuses on providing housing and infrastructure for previously disadvantaged, low income, identification-holding South Africans (Tangri, 2008). These houses were relatively well constructed, using concrete blocks and tiled roofs, and had communal water supplies.

In contrast, Village B consisted of homes made of natural materials – mainly rocks, sticks and branches – and all had tin roofs. These houses were informally constructed and appeared unstable. Residents from Village B were mostly South Africans who were unregistered; they did not have an identification book, which is needed to apply for RDP housing.

Village C was the final area inhabited by South African residents and houses were built in the style of modern Western style bungalows, and were large in size. Each had a garden and most had an indoor bathroom with running water. An emerging middle class of black South Africans lived here.

Village D consisted of overcrowded, poor quality houses, many of which were owned by sugarcane farmers and, historically, had been used to house migrant farm labourers. Empty buildings were occupied by unemployed migrants and all dwellings were overcrowded, of poor quality and without access to sanitation and water supplies.

These four village areas looked very different as they were each characterised by a different style of building. They represented an underlying disparity in income as well as a poor quality of life that is often associated with spaces occupied by many migrants and non-migrants.

Women and men of different ages, backgrounds and migratory origins lived in each of the four village areas. Some lived with their families, some alone, and

some in shared rooms utilising communal facilities. Both younger and older women shared their experiences of migration.

Younger women

Younger participants in this study indicated that they had most commonly been the first family member to move to South Africa. Many had been inspired to move by the experience of friends or neighbours from their home community, as well as their own perception that migrating provided access to wealth, better living conditions, modern clothing and commercial items. Other younger women described feelings of disillusionment with their circumstances, opportunities and prospects in their home communities. In particular, participants from Zimbabwe associated these feelings with political or environmental instability and described how these feelings and experiences pushed them to migrate. Most indicated that they had incurred negative experiences of both the journey and their arrival in rural KwaZulu-Natal. These had resulted in the younger women migrants often adopting high-risk livelihood strategies in order to ensure their survival. These strategies often posed a risk to their own health and their children's health that was sometimes further heightened by reluctance to access primary care services.

The possibility of earning salaries in South African Rands (ZAR) and sending money back to their homes were both major pull factors that inspired the migration of younger migrant women. Some described how they had observed neighbours in their home communities receiving remittances from family members who had previously moved to South Africa and seen the effect the extra income had on the material circumstances of neighbours and returning migrants. One participant explained how this affected the dynamic in her home community:

> I used to see women buying the newest stuff for their kids, new clothes from the expensive shops. Neighbours used to try and do better than each other… build bigger and better, with brighter colours, that sort of thing… Every month, this one family used to go to town and buy cows or a tractor. Then the next month their neighbours would come back with a plough, some goats or a new bicycle, just to prove who had more money (Precious, 22, Mozambique).

The situation described by Precious, above, and the access to sought-after material items appeared to motivate young, female migrants to move to South Africa. As Menenhle explained:

> Me, I wanted nice things. I could only get that if I moved away (Menenhle, 18, Mozambique).

Other younger women explained that they had become disillusioned with life in their home communities. Princess described how a lack of income made her want to move away:

> I didn't like my home because we were poor…I was cold, hungry and by myself much of the time (Princess, 24, Zimbabwe).

Often, younger women wanted to move in order to experience more of life as there were few opportunities for personal growth and no prospects in their home communities:

> I moved because I wanted to see this, to have more of an experience of life that is not just my small village, where there is nothing you can do (Thabsile, 33, Swaziland).

Some women reminisced about how they felt unhappy with their position as women in what were regularly described as strongly patriarchal, gendered home communities. For some younger participants, like Princess, this was a major factor in their decisions to move to South Africa:

> I was living at home and had to do all the jobs, I was expected to be married to someone horrible because his family had money and my family had none. I had no choice… I knew I was having to get away (Princess, 24, Zimbabwe).

A number of younger participants, like Princess, originated from Zimbabwe. They moved from unstable home environments where they felt unsafe and lived in fear of hunger, drought, civil war or political unrest. They lived without income and were worried for their survival. The women saw their migration to South Africa, not as a luxury or a long awaited goal in their life trajectory, but as a necessary move to ensure more secure futures for themselves and their children if they had any. As Thembeka explained:

> South Africa, at least it was better than sitting at home dying slowly like we did in Zim…No food, so much stress about the children, the life there, where are we going to live, our houses…I don't know how to stay there; the problems with the politics and it is all making it impossible to eat (Thembeka, 24, Zimbabwe).

Some younger migrant women indicated that they had often made choices before their move that focused on facilitating their future migration. Some, like Dinance, decided to delay being in a relationship or having children:

> I didn't want a boyfriend, didn't want to get pregnant and have to stay behind. I wanted to move to South Africa for a new start. I didn't want the stress of getting in a relationship and then leaving (Dinance, 30, Mozambique).

Others explained how they lessened their emotional ties to their home communities and households as they were focusing on their impending move to South Africa, which they wanted to be as emotionally easy as possible. Princess said:

> [She] didn't want to have a boyfriend, have a family in that place or make friends, because there was no point, [she] was moving away… (Princess, 24, Zimbabwe).

Many younger generation migrant women wanted to move to South Africa for a safer, improved life. Yet they often described negative experiences of their eventual journeys to South Africa that were characterised by extreme vulnerability:

> I didn't know where I was, I had no knowledge about the safety of the area. I would put my money and my cell phone in my bra, and wrap myself up in layers of clothing. I would sleep very lightly and wake up at the smallest sound… I was also worried about malaria… Usually you are sleeping inside at night, you are safe… I was very, very scared (Menenhle, 18, Mozambique).

Some, like Thembeka, described experiencing rape or abuse:

> A drunk man fell over me and put his face next to mine, he was breathing all over me, it was disgusting, then a sex worker took a customer to the table next to mine, and there were people taking drugs all over the place, walking around with that funny look… I felt so scared, and worried they would rape me or steal from me (Thembeka, 24, Zimbabwe).

Yet most, like Zinhle, were afraid of being alone:

> I was so alone. I missed my family, my sisters, my friends. I had no job… I didn't even know how I would find a job in the morning. I wished I could have gone back home (Zinhle, 22, Swaziland).

The reality of what was available to them as migrant women was often far from the perceived improved economic and social life they had hoped for. Jobs were described as being hard to find and poorly paid. Accommodation was either expensive or associated with exacting manual labour on sugar or banana farms. Tilly explained:

> I looked for a job for many days, then got one but it was hard work… [I] had sores on [my] arms, legs, feet, burns from chemicals on [my] legs… [I] was exhausted, and worked sixteen hour days… [I] only got paid R30 per day. It was the only work [I] could get, and if [I] left [I] would lose [my] room (Tilly, 23, Mozambique).

Often the income earned was a small amount of money, so women found that they were unable to afford to provide for their basic needs let alone send money home. Many resorted to multiple livelihood strategies in order to improve their living conditions and increase their income. However, these strategies were often high risk and made the women vulnerable to abuse and HIV. Livelihood strategies identified by participants included transactional sex, pregnancy for the child support grant through the use of 'grantmakers' who are informal, illegal brokers. Alternatively, they turned to 'sugar daddies,' older boyfriends who often gave valuable gifts like mobile phone airtime, food or cash. Princess described how she resorted to additional income generation methods in order to survive:

> I couldn't afford to live, I needed to send money home, so I started having sex [with an older man] for airtime, mealie meal, clothes. It meant I could send money back home… I got pregnant and I used a grantmaker for the [child support] grant payment (Princess, 24, Zimbabwe).

As a result of relying on livelihood strategies of this kind, many younger migrant women reported health problems associated with pregnancy, tuberculosis, HIV, untreated reproductive health conditions, skin complaints and sexually transmitted infections, that often were untreated. Thabsile described how her actions and choices resulted in her concerns about her health:

> I am in a relationship with a man, he is not like I thought he would be. He drinks, he smokes, and he smokes dagga [marijuana] every day. He doesn't work, but he expects me to. At the end of the month he steals my money and uses it on sex, so I worry all the time about my health. He refuses to use condoms when he sleeps with me, and we already have three children… It makes me stressed that the children are from this horrible man (Thabsile, 33, Swaziland).

Younger women who had children after their migration to KwaZulu-Natal revealed how their own decisions and choices also negatively impacted on the health of their children through HIV-related complications. These complications were mostly the result of not having access to Post Mother to Child Transmission Therapy (PMTCT) whilst pregnant, Thembi explained:

> I didn't take the medicine when I was pregnant, now I am sick, I have HIV. I have children who are sick, they have HIV. I have a boyfriend who is sick, he has HIV. We are all sick… When you have HIV and you do not have the medicine, then you get more sick, you can't breathe, you throw up, you can't work, you can't get food, you eat badly, you throw up more (Thembi, 22, Swaziland).

It appears that these health problems were exacerbated due to the difficulties experienced and the reluctance felt by these younger, migrant women in accessing primary healthcare services. In Thabsile's opinion, she was not alone in her concern over accessing state-run primary care services:

> There is a church person who can give me medicine, but they don't give me the HIV medicine… I don't go to the clinic, I am scared that they will take my children away. I don't take my children to the clinic, because they might send them away… There is no medicine. We all feel this way (Thabsile, 33, Swaziland).

As a direct result of their experiences of migration to South Africa, coupled with concerns and barriers to accessing primary care facilities, it was not uncommon for younger, female participants in this research to describe how gradually, over a number of years, their health deteriorated and many eventually felt unable to care for their children. Some, like Thabsile, described being made homeless, as she became unable to work and had to move into overcrowded, expensive, poor quality accommodation.

> I felt sick… I couldn't move… I thought I was dying and then I was told to get out of my room. I had nowhere to go, so I had to pay to live in a

> shared room, with other sick people… It is bad, really bad (Thabsile, 33, Swaziland).

Many younger women, like Pretty, described feeling despair, sorrow and sadness at their situations and described complex emotions about their situations:

> Some days, I wake up and I just want to give up. I can't go home, I can't stay here. I have nothing… My children have nothing… What is there left? (Pretty, South Africa).

In response to their experiences of poverty, vulnerability, poor housing, chronic disease, deteriorating health and food insecurity, a number of younger women described how they called for help from their mothers. This call for help acted as a pull factor for the older generation of women, working in combination with previously existing push factors such as poverty, instability, environmental or political insecurity and poor living conditions. In combination, these factors acted as triggers for the migration of older women to South Africa.

As a result, there is now an emerging group of older women who are secondary migrants – migratory followers of their daughters – who have moved to rural KwaZulu-Natal ostensibly to help the younger generation of women from their families, but also in response to negative conditions in their home communities. This flow of older women to rural KwaZulu-Natal forms the second phase of this intergenerational dual phase migratory process.

Older women

Older women were mainly migratory followers of their daughters. They were generally willing and eager to tell their stories. They described their home communities, experiences of their journeys to KwaZulu-Natal, their experiences of arrival in the area and their shock and disappointment when they realised the conditions that their daughters, and in some cases grandchildren, were exposed to. They described feelings of sadness and despair at the progressive degeneration of the health of their daughters after their arrival. In contrast with the younger women, older female migrants tended to share stories of their home communities that were associated with positive experiences and memories. Rebecca reminisced at length about her home community in Mozambique:

> Home…the green coconut trees, and the sparkling ocean… There it is beautiful (Rebecca, 60, Mozambique).

Nancy, a migrant also from Mozambique, often discussed her home country and her community. She compared it to how she perceived South Africa:

> Mozambique is a country full of sunshine, colour and beauty. South Africa? South Africa to me is a dull colour, maybe one time it was a bright yellow, but today it has dulled to brown. There is no joy in this place, no happiness. Not even the white man who I see with all his money and his huge farms, they have no happiness in their soul, they are full of sadness, greed and the anger. Anger is in all South Africans. Tell me, how can a country be rebuilt on a foundation of anger? (Nancy, 60, Mozambique).

Women like Rebecca and Nancy often expressed longing and sadness when speaking about their previous lives. They regularly described scenes of husbands, friends and children; living in extended family homesteads; growing food in *'mashamba'* (vegetable gardens) and enjoying the abundance of fresh fish:

> We had a large family, we would all work together, grow our food, the men would catch fish. Nobody was hungry and nobody was sick, it was a beautiful home (Rebecca, 60, Mozambique).

Many women, however, also admitted to experiencing negative factors, such as insecure living and poor quality infrastructure and services including inadequate healthcare provision. In addition, they spoke of challenging environmental factors that included monsoon rains and drought at different times of year.

> We had the civil war… I remember not having food, having people get sick a bit with cholera… sometimes there were landmines (Rebecca, 60, Mozambique).

These experiences, when combined with the pull of their daughters' need for help, resulted in the migration of older women to rural KwaZulu-Natal.

Similar to the women from younger generations, older migrant women also described uncomfortable and unsafe journeys from their home communities to South Africa. Duma's journey to South Africa from Zimbabwe, highlighted the dangers of women travelling on their own:

> I was travelling in the dark and I had to cross the border at Limpopo. It is dangerous, there are men with guns and a lot of people shouting at us… There are a lot of migrants… I managed to get the last place on a taxi, but it was crowded and someone stole food from me (Duma, 40, Zimbabwe).

Even for those already living in South Africa, the arrival in KwaZulu-Natal after a long journey was also unsafe. Zodwa described her experience:

> I arrived very late, and there was no one around really, just a shebeen [unlicensed bar]. I was lucky though, because I found a place where I could rent a room for a night. It was expensive but it is not safe to just sit around. Any tsotsi [criminal] can hurt you (Zodwa, around 50, Trust, South Africa).

However, and perhaps due to the respect that is present in Southern African contexts for older women and men, older migrant women did not discuss experiencing any form of abuse when travelling to South Africa. Rather, their main source of negativity was caused by the emotional trauma of seeing their family members living in poverty. Zodwa described her experience and her feelings:

> Eventually, after three days, I found [my family]. They were living in a room made out of plastic. Horrible bad place, right near by the sugar cane. I had to ask a lot of people to find them… Their house wasn't a house. They had moved from a beautiful house at home, made of bricks, even with a proper, indoor bathroom… This was horrible… This wasn't a real house. I sat and cried before I had the courage to enter (Zodwa, around 50, Trust, South Africa).

Some older women had been expecting to find their daughters living in perhaps cramped conditions, or maybe without enough clothes or space for their children. However, many described being extremely shocked by the reality of the conditions they found their family members living in:

> I knew there was a problem, because [they] wouldn't have called otherwise… I thought maybe there was no money, I thought maybe there was no food sometimes… [But] there was a big, big, big problem, it was a bad situation, very bad…[they] were all so sick, there was nothing… it was terrible (Nelly, 45, Mozambique).

Most alarming for many older women was the noticeable and gradual degeneration of the health of their daughters. Whilst many had travelled to South Africa fully expecting that their daughters would need a substantial amount of help, none had quite imagined the extent to which they were unwell, often incapable of looking after their children and themselves. This was experienced by one participant, Ember, who travelled from Zimbabwe to South Africa, where her daughter and her children were living:

> I came here to look after them, but when I got here… my daughter… she couldn't do anything, then she died…My grandchildren, the one, he is dying... it is my job to try and care for them, to make the one better (Ember, 55, Zimbabwe).

In response to the situations in which they found their daughters and themselves living, alongside their shock and grief, older women drew on great strength. They demonstrated resilience and resourcefulness, and they developed friendship groups for support. Elise explained how her friends helped her make a new life in South Africa:

> I am better now, I have my friends, and we have a small income that comes in, which means that we can help the children [grandchildren]… we live close to each other and we help each other… It is not like when I first got here and I knew nobody. Then it was very difficult… Too hard (Elise, 40, Mozambique).

Through their friendship groups, the older migrant women joined together to help each other. Subsequently, support networks were formed that consisted of women from similar backgrounds who were experiencing similar situations.

Older women also tended to adopt positive livelihood strategies informed by their life experiences in order to address problems and resolve issues found in their new lives, such as vegetable gardening, working in crèches, looking after children and others, caring and informal trading. Jabu described how she came about starting a vegetable garden:

> I didn't have money to buy food, but I had my skills, so I looked for a chance to use them and found one [making a vegetable garden]. Now we have food for our whole house, and money when there is extra to sell (Jabu, 42, Mozambique).

In many circumstances, the daughters of these older women eventually passed away, dying from complications associated with their HIV status or the later stages of AIDS. When this happened, the older women described being left to care for their extended families, or others from their community, which often included young grandchildren or children of other women. For example, Dudu started an informal crèche looking after the children of sick women in the community. She described her feelings:

> I can't help myself, so I need, now, to help others… My daughter, I came here for her and then she died… Many, many have died and left poor children behind. I can't go home, I don't have the money and I will not have the money – now I definitely will not have the money, because I have so many children – and so rather than sitting here in this place, I need to help the people that need it. Those people are children. I am committed now, to dying in this place… My friends are committed now to dying in this place. We are needed here to help (Dudu, 45, Swaziland).

A community of older, proactive female migrants, therefore, has been formed in a rural area on the north coast of KwaZulu-Natal. The community is a source of support, help and friendship to members, and many share or trade food, clothing and school uniform or medicines for themselves or their grandchildren. Most of these older migrant women feel that rather than being absorbed by negativity in their new-found situations, it was important to concentrate on the positive. Most were prepared to stay, living positively in KwaZulu-Natal, mostly for the benefit of their grandchildren. As Jabu explained:

> I was sad, yes, when I first came, but as I made friends and created a job for myself, things got better. Now I have good friends, an income and I have my grandchildren… My grandchildren need me here, not in Mozambique. I am not unhappy that I will stay here forever… Yes, I sometimes miss home, but there are also things that I am glad to be away from (Jabu, 45, Mozambique).

The majority of these older generation women portrayed a positive attitude towards both their own and their grandchildren's health, unlike their daughters before them who had experienced concern about accessing state healthcare and other facilities. Duma described her experiences asking for help at the local clinic:

> I am old, I do not care what people think of me, I go and ask for medicine if my child is sick, they must give me… it is their job. I do not care what they think of me, coming from Zimbabwe when my child needs medicine (Duma, 40, Zimbabwe).

As a result of the attitude of grandmothers like Duma towards the health of their grandchildren, many children are now attending school as well as receiving health care. Despite the proactive nature of the older women in terms of their grandchildren's health requirements, it should still be acknowledged that there are complex primary care requirements specific to this growing community of ageing migrant women in relatively good health. As Jabu explained:

> I go all the time to the clinic for my grandchildren… I am selling the vegetables to get the money to travel with them on the taxi… the [grandchildren] then do not have to walk to get their medicine… I think they get everything they need… When I go to the clinic with [my grandchildren] I also ask for myself, sometimes I am feeling dizzy, sometimes I am getting [bashes her chest where her heart is] and a bit of pain here, I find it difficult to walk sometimes and breathe but there is nothing they can do to me, just send me to some hospital (Jabu, 45, Mozambique).

Whilst older migrant women like Jabu experienced positive care at primary healthcare clinics for their grandchildren, the services provided were related to HIV and basic primary care. However, there is a clear difficulty in accessing primary care services that catered for their own health needs, which were concerned with women's health requirements in later stages of life.

Conclusions and recommendations

This study identified a shift in migratory patterns in a rural area of Northern, coastal KwaZulu-Natal Province in South Africa. The data demonstrate that there is gendered dual phase intergenerational migration, in which younger women migrate and are then followed by related older women. These older women are generally their mothers. The pattern of migration identified here is single direction, and interregional. Previous research from the Africa Centre DSS identified that migration to this area is a cyclical process associated with women from younger generations, from different areas of South Africa, who move for labour purposes and then return home regularly for visits out of season (Camlin et al, 2014; Bennett et al, 2014). However, this study identified

that, rather, there is a dual phase, interregional and intergenerational process of migration that affects both younger and older women. Younger women were likely to move to the rural, farming area from neighbouring Southern African countries in order to find work and improve their own lives. These women can be described as migratory leaders. However, the women's experienced reality of their participation in this gendered migratory flow was not always as they had hoped and expected. In order to cope with negative experiences, younger women resorted to the adoption of multiple and risky livelihood strategies in order to stay alive and make a small income. However, these livelihood strategies often made them vulnerable to HIV infection and, as a result, many contracted HIV and were often unable to care for their children. As a direct result, their older mothers moved to the area and, in turn, adopted positive strategies to survive and demonstrated resilience when coping with their new-found life circumstances. These older women can be described as migratory followers.

It can also be ascertained that the construction and development of households in this area of KwaZulu-Natal Province can be directly attributed to this pattern of migration. This finding is not dissimilar to that identified in the Eastern Cape by Neves and Du Toit (2008). However, Neves and Du Toit understand that historical-political nuances in South Africa impact household construction, whereas this is an emerging migratory pattern rather than one that is historically and socio-politically grounded.

As a direct result of this shift in migratory patterns, there is an expanding group of older, migrant women who are affected by the repercussions of the HIV status of their family members. These older women are living in the rural areas of KwaZulu-Natal Province. These women require assistance in terms of financial support, primary care for degenerative disease, as well as recognition for the support they provide to their kin and members of their communities. Further research could explore the extent to which this is or can be provided by rural, primary healthcare clinics and what improvements could be made in this respect.

We would further argue that this gendered intergenerational international dual phased process of chain migration might not be specific to the study location or even, the KwaZulu-Natal Province. This trend may be occurring more widely in other areas of urban and rural South Africa. Inclusion of a relevant question in national level household surveys such as the Demographic and Health Survey (DHS) or the Human Sciences Research

Council (HSRC) Household Survey detailing migratory origin and behaviour of respondents could extend understandings of the generalisability of these findings. These findings raise further issues concerning health care provision and support for both younger and older women.

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