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Redeeming Lost Mothers: Adolescent Antiretroviral Treatment and the Making of Home in South Africa

Beth Vale[a] and Mildred Thabeng[b]

[a]Department of Social Policy and Intervention, Oxford University, Oxford, United Kingdom; [b]Department of Social Work, University of South Africa, East London, South Africa

ABSTRACT

In this article, we explore how adolescent antiretroviral treatment (ART) might be signified to repair sociality in Eastern Cape homes that have been ruptured by HIV/AIDS and maternal loss. The post-apartheid period has exposed these families to new forms of social fragmentation, propelled by the disintegration of wage labor, declining marriage rates, and a rampant HIV/AIDS epidemic. Drawing on eight months of ethnographic fieldwork (August 2013–April 2014), we show that in the homes of some adolescents born with HIV, these present-day domestic ruptures were discursively connected to the past shortcomings of their dead and absent mothers. In some familial narratives lost mothers were accused of disobeying their elders, neglecting their children, and flouting custom; their social transgressions were made manifest in their child's inherited HIV. By signifying adolescent ART-taking as an enactment of the discipline and care purportedly absent in their mothers, these families might also attempt to imbue ART, beyond its biomedical function, as a means of social repair.

KEYWORDS

Adolescent; antiretroviral treatment; HIV/AIDS; mothers; orphans

In this article, we explore how adolescent antiretroviral treatment (ART) might be inscribed as a way to ritually augment familial ties in homes fractured by HIV/AIDS and maternal loss. This study forms part of a collaborative research project, *Mzantsi Wakho* (Your South Africa), which investigates adolescent ART and sexual and reproductive health in the Eastern Cape. Ours was a small qualitative study, investigating how some HIV-positive adolescents and their families appropriated ART amid the social complexities of their everyday lives.

The analysis presented here draws on eight months of qualitative fieldwork with 18 perinatally infected adolescents (aged 10–19 years) and their families, in households in which the biological mother was either dead or absent. Those who have assumed the role of caregivers are tasked with rebuilding sociality in the home, while also integrating HIV treatment into its domestic rituals. This problem is distinctly generational: first because the loss of the mother often entails the loss of a middle generation, demanding that ties of mutuality and respect be rethreaded across the generational divide; and second because to treat an inherited illness is precisely to attend to the misfortunes of the past in the present.

We are interested in how ART might be signified to bridge these temporalities: how the biographies of children are invoked in providing ART care for children's children; how modern medical technology might be taken paradoxically to re-instate imagined tradition; and how contemporary biomedicine can be re-invented as a social treatment for the shortcomings of the past.

CONTACT Beth Vale beth.nosizwe.vale@gmail.com Department of Social Policy and Intervention, 32 Wellington Square, Oxford, Oxfordshire, OX12ER, United Kingdom.

Art and biosociality

Following a period of widespread, unavoidable AIDS death, the public provision of life-preserving ART was a watershed moment for the developing world. Researchers have documented the frequently evangelical idiom in which ART is articulated among those with newfound access (Dilger, Burchardt, and Van Dijk 2010). ART users in West and Southern Africa have been described as giving "testimony" to the "revelations" of AIDS science (Nguyen et al. 2007; Nguyen 2009), "resurrected" from near death to "new life" on treatment (Robins 2006, 2009). From support groups in Bukino-Faso (Nguyen et al. 2007), to Treatment Action Campaign members in South Africa (Robins 2006), to the social movements of Brazil (Biehl 2004), treatment activists have narrated their illness experiences, galvanized collective identities, and drawn on their biological status to make claims on both public and donor resources. Accordingly, AIDS activists have been cited as primary examples of "biosociality" (Rabinow 1996; Rose and Novas 2005:449)—organizing self-help and solidarity premised on shared biomedical diagnoses.

As ART rollout has expanded, so too patients have been urged to become active and 'responsible' medical consumers. ART users are pressed to comply with a set of self-help behaviors that signal 'positive living.' These include treatment adherence, safer sex, restricted alcohol consumption, regular clinic appointments, and HIV status disclosure (Dilger 2012:70; Richey 2012). Hence, alongside their 'empowered' testimony and activism, ART users have become known for their docility in conforming to prescribed "regimes of care" (Marsland 2012:471). ART has therefore given rise to new modes of biosociality, sometimes depicted as enabled, rights-driven citizenship, at other times as dependent, disciplining clientship (Mattes 2011; Richey 2012; Meinart, Morgensen, and Twebaze 2009).

While these and other authors have explored the appropriation of ART as rights, relationships, and responsibilities vis-à-vis state and donor programs, less attention has been given to how ART might serve as an expression of obligation, relatedness, and dependency in the home. This is despite the fact that the home is a primary site for ART, and is a fundamentally 'biosocial' entity. Here, mutuality, obligation, and identity are premised on biological categories.

As a virus transmitted through sex and blood ties, HIV troubles the very sites of familial connection and relatedness. Hence, while serving as a biomedical treatment for the blood, ART might also work symbolically to repair social damages to bloodlines and blood ties. Values of discipline and obedience, traditionally invoked in producing a self-reliant ART user, might be re-signified to strengthen relatedness and reciprocity among relatives. As we will show, in some households in this study, these ideals were asserted and inculcated into adolescents' ART-taking precisely because they were purportedly lacking in their dead and absent mothers. The ritualized consumption of ART was signified not only for the 'resurrection' of adolescents' health, but also for the 'resurrection' of 'home' as a biosocial project, stretched across time and space.

Contributing to a wider literature on the "social lives of medicines" (Whyte, Van der Geest, and Hardon 2002), in this article we explore how medicine is appropriated not only for the control of physiological symptoms but also for social situations (Whyte et al 2002:15).

Research setting and methods

Between August 2013 and May 2014 we conducted multimethod ethnographic research with 23 adolescents in two Eastern Cape sites. The first four months were spent in rural villages of the municipality we call Mtembu, and the second in peripheral informal settlements of a peri-urban town we name Ridgetown. In December 2014, we conducted one-off interviews with two additional adolescent girls, who were recruited as part of *Mzantsi Wakho*'s quantitative cohort. Both were living in a peripheral informal settlement in one of the province's largest cities.

The majority (18) of adolescents in this study were recruited through nongovernmental organization (NGO) ART support programs with help from NGO staff. In rural Mtembu, a small development NGO was facilitating adolescent ART support workshops a few times

annually, and these activities were complemented by intermittent home visits from village health-workers. In Ridgetown, a palliative care organization facilitated weekly ART support groups for adolescents.

Participants were purposively sampled for variation in age and gender, with the further intention of including harder-to-reach subgroups. The latter included adolescents who did not know their status, those infected sexually, and those known to be defaulting on treatment. To fill gaps in the sample and reach those excluded from NGO support, seven additional adolescent participants were recruited through public health clinics, with nurses and data capturers facilitating referrals.

Of the 25 adolescents recruited for this study, 21 were infected perinatally, and among these, 18 had mothers who were absent or had died. These adolescents are the focus of this article. Throughout fieldwork, we visited adolescents and their families regularly, immersing ourselves as far as possible in their everyday lives, talking informally while they were cooking, washing clothes, playing sports, or sharing meals. We also accompanied adolescents and their relatives to medical appointments and support groups to observe how HIV treatment was narrated in these institutional settings.

Engagements with adolescents were ongoing, and comparatively informal. In addition to our casual conversations, visits sometimes included explorative interviews, occasionally using games and pictures as prompts. Emerging discussions covered adolescents' family relationships, daily lives, pill-taking practices, and HIV illness history. While some ethnographic observation involved family, friends, and health-workers, most interactions with adolescents were private. We also conducted semistructured, recorded interviews with professional and lay health-workers, and with the guardians of almost all of these young people to trace adolescents' care trajectories. Where both biological parents were absent, interviews began with the prompt, "Can you tell me how you came to care for X?" Conversations were intended to explore experiences of caregiving, charting adolescents' HIV diagnoses, ART practices, and present-day home lives.

Research methods were adapted in the field according to participants' responsiveness, which varied by age, attention span, and cognitive ability. Methods were designed to create a nonthreatening, stimulating research environment, balancing noninvasive participation and guided interaction. All research activities were carried out in both English and isiXhosa with real-time translation. This allowed for instantaneous interpretation of participants' responses, which informed follow-up probing. Unless otherwise stated, interview quotes do not reflect participants' responses verbatim, but are instead a representation of respondents' perspectives through the words of the translator. Although we conferred regularly about captured translations, the emerging data were undoubtedly influenced by complex in situ interpretations and possible misconceptions.

Data collection and analysis began simultaneously with field research and emerging themes mutually informing one another. Recurring, unprompted references to missing parents, and mothers in particular, encouraged us to ask some adolescents and guardians: "What do you/your child know about your/their mother?" Following fieldwork, the first author was responsible for thematically coding the data and preparing the manuscript (Miles and Huberman 1994). In this article, we reflect on interconnections between emerging themes related to death, intergenerational care, pill-taking, and missing parents. Paying attention to how, and in what contexts, participants invoked missing parents, we discovered overlaps in how dead and absent parents were narrated, and that mothers, in particular, were demonized. Participants' invocation of dead and absent mothers in the context of ART was striking. When related to other ART narratives, the analysis revealed recurrent appeals to intergenerational reciprocity to signify and bolster adolescent ART.

Pseudonyms are used for both participants and research sites. Locations and identifiers are kept deliberately vague in order to protect anonymity.

Households

Apart from those in Ridgetown, most participants in this study were living in former Eastern Cape 'homelands.' Designated by the Apartheid government, these territorial reserves were allocated

exclusively for black residents. Consequently, they were deliberately underdeveloped and under-resourced (Nell, Hill, and Binns 1997:58). The Eastern Cape remains one of South Africa's poorest provinces, with a 30.6% unemployment rate (Statistics South Africa 2014). The few adult carers in this study who were able to find work mostly had short-term contracts as domestic workers or casual laborers. Most households relied on the post-1994 social grants economy, and were recipients of foster child, disability, pension, or child support grants.

In 2011, 49.6% of households in the Eastern Cape were headed by women (Census 2011). Under apartheid labor laws, black men travelled from the country's homelands to work in urban areas and were mandated to leave their families behind (Richter and Morrel 2006:4). In the post-apartheid period, female-centered homes have only been further entrenched (Walker 2013:84), while men are increasingly peripheral to the project of domestic reproduction (White 2001). Plummeting employment opportunities, particularly in the industrial economy, make it increasingly difficult for men to occupy the position of patriarch and breadwinner (Bank 2001:145). Meanwhile, the number of women in the labor force continues to rise (Casale and Posel 2002), accompanied by a decline in marriage rates and the resulting "uncoupling of motherhood and marriage" (Walker 1995:431).

Female-headed homes are further supported by an expanded social security system, for which women, in their position as carers, are primary targets (Statistics South Africa 2010:5; Patel et al. 2012:2). Older women have found their position particularly bolstered by state pensions, which until very recently, were set at a lower age eligibility criteria for women than men (Schatz et al. 2012:3). In many households, grandmothers have replaced wage-earning men as economic lynchpins (Bank 2002:641). These granny-focal domestic arrangements are further necessitated by a frequently-missing middle generation, some lost to AIDS and others to the perpetual search for work (Schatz 2007). Of the 18 adolescents under discussion here, all but two continued to live in female-headed homes, and of these, 11 were cared for by grandmothers, sometimes in combination with other relatives.

Given these structural conditions, it is not uncommon for South African children to be raised without social or financial contribution from their fathers (Richter and Morrell 2006), and this has also lessened the care contribution of patrilineal kin (Anderson 2005:25). Among the 18 adolescents in this study who were living without their mothers, 16 also lived without fathers, and seven had never known their fathers. Thirteen stayed with maternal relatives after the death or departure of their mother, and many had lost contact with paternal kin altogether.

Death and dispersal

HIV prevalence in the Eastern Cape is 11.6% and the province is home to 23% of South Africa's AIDS orphans (Hayward 2015). Nine of the young people in this study had lost mothers to AIDS illness; a further three had lost both parents to AIDS. Among those whose mothers had died, nine had to move homes soon after, posing challenges for integration into a new family. Amid death, dispersal, and severance, there were shared and shifting caregiving arrangements, conflicting claims to care, and shaky transitions from one caregiver to another. Ntombi's uncle, for example, recounted how he and his wife came to care for Ntombi (age 14). They had taken her in after a series of deaths in her mother's family, and the purported failure of her surviving matrilineal kin to assume responsibility for her care:

> Ntombi's mother died [in] 2009. She was my sister-in-law. Then after her mother died, the sister of her mother took over [her care]. But again she also died […]. And then no one wanted to take Ntombi. I don't know why, because Ntombi has a grandmother, an aunt and other family. (February 21, 2014)

Ntombi's uncle was one of very few men in our study who had assumed care of a young person. In all other cases, grandmothers carried or shared the caregiving burden, but because his wife worked, Ntombi's uncle was primary caregiver. In relaying how he, a male relative, came to care for

Ntombi, he recounted a legacy of lost and negligent female kin: first, the death of Ntombi's mother and maternal aunt, both of whom he described earlier as reckless alcoholics; then, the failure of Ntombi's maternal grandmother and maternal aunt to assume responsibility for her care. In the wake of these sudden losses and the perceived abandonment of caregiving responsibilities, the remaining family were left to 'pick up' the social strands.

Reflecting on her own struggles to integrate into a new home after her mother's death, Wandi (age 19) described how she received inferior care living without her biological parents: "[Before her death] my mother loved me and spoilt me. Now my aunt sometimes shouts at me and I feel pain. And she's choosy. There's unfair treatment between me and her children."

While AIDS deaths had an immensely destabilizing effect on many adolescents in this study, this loss was rarely isolated. Some young people lost parents in violent crime; many more experienced loss in the form of an estranged or absent family. Four of the young people in this study were rural adolescents with parents living and working in urban centers. A further four were living in the same peri-urban neighborhoods as their biological parents, but with little or no contact with them.

Households in the Eastern Cape have been spatially stretched for decades (Neves and Du Toit 2008), and AIDS deaths are not always delineated from other forms of loss. Instead, they might be understood as part of "a long procession of misfortunes" (Becker and Geissler 2009:11). Like those whose mothers had died, Naledi (age 18) worried that her mother's absence had damaged relationships in her home. When Naledi was still a baby, her mother left home to find work in the city. This, Naledi thought, had troubled the relationship between herself and her grandmother. Naledi believed that her grandmother viewed her as a living instantiation of her absent mother; her interactions with her granddaughter reflected her resentment of her daughter. Naledi once asked, "How can she [my grandmother] hate my mother and love me?" For Naledi, familial sociality was mediated by the specter of her absent mother, who continued to act as an interlocutor between herself and her grandmother. While adolescents were concerned about the social damages of their mothers' death or absence, caregivers worried about their ability to substitute for biological parents.

A few expressed anxiety about the effects of adolescents growing up "parentless": Mpho's aunt, for example, worried that feelings of "parentless-ness" might lead Mpho (age 13) to a premature sense of "independence" and lawlessness. In a family interview, she recalled how she had tried to discipline Mpho, who responded by shouting: "Why are you beating me? Why can't you take care of your own child and leave me alone?!" Mpho's support group facilitator also explained Mpho's anger towards her family as a symptom of "parentless-ness"—an indication that she "misses her mother." In these narratives, attending to the missing mother is positioned as integral to maintaining harmonious relationships in the home.

Thus far, we have described how familial death and disappearance—particularly of mothers—is perceived to threaten domestic conviviality. In the life trajectories of adolescents in this study, care has often been adaptable, transient, and highly contingent: In response to migration, illness, death, or absence, the role of guardian has been shifted and shared among adult caregivers. The fluidity of these caregiving arrangements has helped to buffer multiple losses.

Other researchers have explored how Eastern Cape families have attempted to socially and ceremonially sustain the home amid chronic economic insecurity and domestic fragmentation. Zolani Ngwane (2003), for example, examined the ritual return of urban-based relatives to the countryside over Christmas time. This "ritualized drama" signaled a performance of coherence, through which families "approximated imagined households" (Ngwane 2003:688). Similarly, Andrew Ainslee (2014) described Eastern Cape families' relentless enactments of ancestral rituals as tenuous attempts to sustain social ties. We are interested in how ART might be inscribed into familial repertoires of care that seek to rebuild sociality amid domestic fragmentation. We suggest that among some families, the appropriation of ART might be discursively mediated through stories that demonize dead and absent mothers.

Gendering the HIV/AIDS epidemic

Despite high levels of paternal absence, accusations of reckless negligence always circulated around mothers, and stories about mothers were significantly more pervasive and tangibly more emotional. This may be because fathers have historically been removed from caregiving contexts, but we believe also because mothers are attributed the weight of blame for their child's HIV status. Even 'prevention of mother to child transmission' (PMTCT), now a default phrase in ART programs globally, arguably assigns blame to mothers in place of more neutral alternatives like 'prevention of vertical transmission' (Young et al. 2011:225).

At 24.6%, HIV prevalence among young women (aged 25–29 years) is higher than any other population group in South Africa (Department of Health 2011). Women are especially targeted by HIV services, with many initiating ART through antenatal care (Cornell, McIntyre, and Myre 2011:628; Mills, Ford, and Mugyeni 2009). The coupling of higher prevalence and higher clinic attendance makes women the more visible HIV carriers and the most stigmatized. The feminization of HIV has seen the cultural transgressions and 'excessive' sexual desires of women blamed as both the cause and the spread of HIV (Leclerc-Madlala 2001, 2002, 2005; Campbell, Nair, and Maimane 2006:134; Denis 2014; Dilger 2003:34). Most recently, Philip Denis' research among support group members in KwaZulu-Natal found that women continue to be seen as vectors of AIDS, impugned for infecting their male partners (Denis 2014:290). Next, we turn attention to how this misogyny might take expression in underexplored matrifocal spaces.

The demonization of dead and absent mothers

In explaining how they came to care for an adolescent with inherited HIV, many family members recounted stories of dead or absent mothers. In doing so, interviewees rarely spoke well of missing mothers, even when referring to their own daughters. In their conversations, guardians seemed to castigate dead and absent mothers, both to explain the family's current burdens and to present themselves as comparatively praiseworthy. Demonizing talk about mothers was also narrated to adolescents themselves. Here, the myths constructed around mothers seemed to serve as cautionary tales for adolescents not to repeat their mothers' mistakes.

At the same time, narratives of maternal loss were imbued with deep pain. This stemmed from the premature death or persistent absence of a family member, as well as the weighty inheritance of an orphaned child with a life-threatening condition. Mothers were also not wholly condemned; while learning of the mistakes of their mothers, some adolescents were also told that their mothers "loved them" and were ultimately "good." This variance is important, since by conjuring stories of both the failings and fundamental goodness of mothers, adolescents were encouraged to redeem their mothers' memory. Even so, the most dominant narrative was the purported recklessness of mothers, whose behavior was spoken of with regret and sometimes resentment. Many mothers were completing school during pregnancy and were considered too young to properly care for their babies. Others were accused of promiscuity and heavy drinking. Families spoke too of mothers who abandoned their children—fleeing the homestead in pursuit of work, or dropping their child off with relatives and disappearing soon after. Citing this maternal neglect, Bongani's (age 17) paternal aunt declared: "I would never give him [Bongani] away to his mom because she never really looked after him." Mpho's aunt described her absent mother as being similarly uncaring, constantly reneging on her promises to Mpho.

Where paternal family were caring for adolescents with lost mothers, accusations of negligence occasionally extended to the maternal lineage. Before moving in with his paternal grandmother and aunt, Xhanti (age 13) had been living with his maternal grandmother, who his current family described as "very cruel." One day, Xhanti's mother arrived at the door of his paternal family and asked them to take over his care, since her own family was mistreating him and she was still in school. Xhanti's family told us that the young child had arrived at their house "drunk" after being

"fed alcohol," and that he was so sick they thought he would die. Through narratives that demonized his maternal relatives, Xhanti's family sought to demonstrate to Xhanti and to us as researchers that they were the more capable caregivers. Having been involved in contestations with his maternal kin over the rightful recipients of Xhanti's foster care grant, this performance was significant.

The stories told by Nonkosi's (age 17) grandmother are a fairly typical example of how women were represented. Nonkosi's grandmother was caring for five grandchildren—two on ART. None of her own children lived with her any more, but two daughters, including Nonkosi's mother, visited intermittently. During her interview, Nonkosi's grandmother recounted how sick his mother had been before being diagnosed with HIV. Soon after this interview, another of her daughters was hospitalized for tuberculosis (TB). Nonkosi's grandmother said she blamed her daughters: they should not have had babies outside of wedlock, before they had homes of their own. "They should have followed my example," she said, asserting that she had waited until moving in with her husband before having children, although she was still a teenager when she married: she had been given away to a much older man after a series of pre-arranged agreements between their two families. Nonkosi's grandmother attributed the family's misfortune to her daughters' inability to follow the example of their elders. They broke with tradition and had babies outside of marriage without a home in which to raise them. Suggesting that her daughters continued to neglect their children, Nonkosi's mother said that they "did not send money." She insisted that she "loved her grandchildren" and "would do anything for them, even though their parents did not send any money."

Nonkosi's grandmother once remarked that all her eight children had been well and healthy, "until Nonkosi's mother got sick." Since then, she had suffered the death of a child and a grandchild. Another child, and two grandchildren, had since been diagnosed with HIV. While she recounted a chronological sequence of events, she implied that Nonkosi's mother might be the catalyst for these misfortunes.

One morning, we sat in Nonkosi's lounge, waiting for his mother to arrive so that we could transport her to the clinic to collect Nonkosi's medicine. Nonkosi's grandmother busied herself with ironing. As time passed, the grandmother became increasingly upset. She commiserated that Nonkosi's mother "liked men and that's why she behaved like this." "When this sort of thing happens," she continued, "I sometimes call the police." It was unclear whether calling the police was a concerned response to her daughter's disappearance, or (as suggested by her tone) a criminalization of her daughter's 'behavior.'

Immediately after, Nonkosi's grandmother showed us a picture of Nonkosi's younger brother, who she explained had died as an infant. While this sequencing may have been coincidental, it seemed to imply a link between the reckless, 'promiscuous' behavior of Nonkosi's mother and the death of her youngest son. In households like Nonkosi's, where ubiquitous death and illness have been concomitant with changing practices of marriage and childbirth, women are perhaps doubly incriminated, not only for the physical transmission of a life-threatening illness but also for the moral and social offenses that precipitated this.

Ntombi's mother was similarly indicted for flouting traditional practices. In his interview, Ntombi's uncle relayed Ntombi's struggles since her mother's death:

> She [Ntombi] suffered really, a lot, because she doesn't know her father. Ntombi's mother died and never told Ntombi who is her father. She [Ntombi's mother] was drinking, too much drinking. That is why we are not sure who is the father of Ntombi.

Not knowing her father was seen as a problem because, without this knowledge, Ntombi could not be introduced to her patrilineal ancestors, and thus could not be afforded their protection. While the loss of her mother and father each had their own ramifications, Ntombi's mother was ultimately blamed for the severance of ancestral ties; she was too reckless to recall the father's identity.

Mothers on ART

When dead or absent mothers had been able to access ART, accounts of their deviance often circulated around their misuse or neglect of treatment. In the most extreme case, we were told that Mpho's mother had tried to kill baby Mpho by deliberately overdosing her on ART. But most often, the accounts were of women who failed to take their own pills properly, and had since lost their lives.

Returning from a funeral to meet with us at her house, Nonkosi's grandmother exclaimed: "Every Saturday there are funerals and they are always for young people." She explained that some of these funerals were mourning AIDS deaths—those of young people who had "left their treatment." *Bayadefaulta!* (They are defaulting!), she exclaimed. By identifying these dead as "defaulters" who had consciously "left their treatment," Nonkosi's grandmother also seemed to be signaling something disgraceful, even blameworthy, about their deaths. Here, blame came not from the moral corruptions that have traditionally designated AIDS deaths as shameful, but from an additional moral order assigned by AIDS science. A new kind of 'sinner' is articulated in the scientific language of 'defaulter.'

While the misdemeanor of 'defaulting' might be sufficiently commonplace to have entered common parlance, this rarely seemed to diminish its derision. In a context of ART access, the offense of defaulting might not only be a case of individual negligence, but also of historical ignorance; the individual fails to show gratitude for this new treatment, and so fails her generation. This further demonized women who died because they did not adhere to ART, and set a moral mandate for adolescents not to make the same 'ungrateful' mistake.

New context, old patriarchy?

Earlier we described a new domestic terrain in South Africa: the role of adult men in domestic life has declined and marriage is less common. Meanwhile, ties of female filiation buttress not only the material composition of many households, but also their social fabric. One might ask: How have families sought to make this emerging matrifocal order workable? And further: Why might the practice of blaming and demonizing women be reproduced in homes where women are central?

These matrifocal arrangements have not necessarily been kinder or fairer to women. In the homes considered here, it was perhaps precisely because women carried so much responsibility that they were also most susceptible to blame. In an increasingly matrifocal order, in which kinship obligations fall most heavily on mothers and matrilineal lineages, women may be especially vulnerable to blame. Perceived to have failed in their obligations, some dead and absent mothers were considered deserving of harsh recrimination. By blaming young women, some guardians might seek to make a 'new' matrifocal order practicable, buttressing adult authority, such that those who had to lead could do so. Their invocation of 'traditional' patriarchal values, rather than being viewed as anachronisms, are perhaps best understood as productive, reflecting very contemporary meanings.

ART and the rethreading of family ties

In this study, fractures in domestic sociality were articulated as damages to intergenerational reciprocity—for which mothers were often held responsible. As we have illustrated, missing mothers were accused of a series of *generational* offenses, both charged with neglecting responsibilities to their children and for disrespecting their elders and customs: having a child out of wedlock, not introducing their child to her father's ancestors, or engaging in promiscuous sex. A few mothers too, by failing to adhere to ART, were seen as ungrateful for their generation's unique access to treatment. These demonizing narratives relayed a particular temporal circumstance, in which the past transgressions of dead and missing mothers continued to trouble domestic life.

In the Eastern Cape and elsewhere in South Africa, a household's contemporary misfortunes may be read through shortcomings of its ancestral past. In KwaZulu-Natal in particular, anthropologists have documented how the incomplete or inappropriate actions of past relatives are taken up by their kin to be attended to in the present (White 2001, 2010; Henderson 2012). Hylton White (2001) relayed the story of a young man, S'Khumbuzo, who had been unable to find work in the city and was thought to be descending into a life of thuggery. S'Khumbuzo's present-day misfortunes were perceived to be linked to those of his estranged migrant elder, who left his rural home to work on the Johannesburg mines, only to be killed and buried in an unmarked grave. In order to attend to the troubles of the present, connected to those of his forefathers, S'Khumbuzo was required to ritually 'fetch' the spirit of his elder and bring him home. Living relatives serve as proxies for their alienated and estranged dead, "carrying their absent bodies" through the actions that might complete their unfinished work and thereby diminish the inherited burdens of surviving kin (White 2001:464; 2010).

In line with these themes, Patti Henderson (2012) documented how AIDS-orphaned children in KwaZulu-Natal ritually substitute for deceased adults in an attempt to re-inscribe "live-able sociality" within the family. Henderson cited a case in which a young boy and a grandmother stood in for a deceased bride and groom, who had intended to marry before losing their lives to AIDS. In doing so, the family not only attended to the incomplete desires of the deceased couple but also cemented relationships and obligations between the two families, which would bear fruit for surviving kin.

However, in this study, rather than completing the work of dead mothers, the living may seek to un-do or re-write their mistakes in the present. Here, adolescents might 'carry' their mothers' 'absent bodies' through disciplined pill-taking and sanctioned behavior. Similarly, some adolescents attested to the ways in which grandmothers 'became mothers': "When I was growing up, I was calling—even now I am calling her [my grandmother] mom. Because I see her. She's the one … who is looking after me, and then I call her mom" (Siya, age 18).

In serving as proxies for dead and absent mothers, both adolescents and their grandparents might seek to reshape space and time—invoking those dead and gone to tackle the mistakes of this missing generation and, in the best cases, strengthen intergenerational ties.

Families were invested in the health and futures of their young members and had myriad reasons for supporting ART, particularly as a route to long-term health and the pursuit of a 'normal' adolescent life. As we show next, families inscribe ART as part of a tenuous attempt to reconstitute fragile and fragmented generational ties. Stories of dead and absent mothers might mediate this work.

Avoiding my mother's fate

Our conversations with Wandi (age 19) illustrate one of the ways in which tales of lost mothers might urge adolescents to recall and rewrite their mothers' past mistakes, through present-day ART-taking. Wandi described the day her aunt told her that her HIV was a maternal inheritance. Directly after informing Wandi of her mother's HIV status, Wandi's aunt had told her that her mother drank excessively and had failed to adhere to the pills that would have prevented Wandi from contracting HIV. This was followed by a moral message: "She [my aunt] explained that my mom did not last long because she did not accept her status. She said if I also don't accept my status, I won't last." Wandi thought she had been told these stories because "my aunt wants me to be strong so that I can stop thinking about this thing about being HIV [positive] and take my medicine." Wandi interpreted this as an instruction to "be strong" and "take her medicine." In doing so, she might also confront, even rewrite, her mother's mistakes.

Andile's aunt relayed a similar narrative. We asked whether Andile (age 13) had ever had questions about his mother. "No," his aunt replied, "But he knows about his mother's death. I sometimes tell Andile when he doesn't take his pills that his mom also didn't take her pills and that's why she died."

In these cautionary tales, it was not only the invocation of the dead mother (and her mistakes) that was important, but also death itself. By recounting the death of adolescents' mothers, these aunts highlighted the proximity and real risk of death. In taking ART, Wandi and Andile might embody their mothers' 'second chance'—to live, adhere to treatment, and care for their family.

Mediating taboos

Although she had never spoken to Andile directly about his HIV status, Andile's aunt had constructed a narrative to explain to him the origins and purpose of his pill-taking. Andile was told that he had "chest problems" which he inherited from his deceased mother, that she had failed to adhere to ART, and so had death. Andile's mother was only invoked in relation to him taking pills.

Xhanti (age 13) was similarly unaware of his HIV-status, and had been told that he took medication for "heart-ache," which his family presented as a maternal inheritance. During a game that encouraged participants to enact their pill-taking using sweets, we prompted Xhanti to tell us what he thought about before taking his pills each day. He responded that he thought about his dead mother: "She took pills too—the same ones I am taking." "What else do you know about your mother?" we asked. "I only know this," he responded.

Both Andile and Xhanti's families avoided speaking explicitly with them about HIV or the cause of their mothers' deaths, believing them to be "too young." The narratives they told served euphemistically to explain adolescents' lifelong illness, without explicit mention of HIV. Such stories of maternal inheritance mediated, or tempered, traditionally taboo conversations about HIV, helping to maintain the bounds of what people considered appropriate intergenerational talk, and so preserved domestic conviviality.

Intergenerational reciprocity

The demonizing narratives under discussion functioned with greater depth and complexity than the simple dictum: "Take your pills so as not to be like your deviant mother." Recall that mothers were primarily charged with having damaged intergenerational reciprocity. On many occasions, ART appeared was narrated as a way to nurture these generational ties.

In line with many charges leveled at missing mothers in this study, Naledi's mother was accused, by her grandmother, of having been sexually reckless, abandoning her AIDS-sick child, and failing repeatedly on ART. But in her interview, Naledi's grandmother was deliberate in showing us that Naledi was *not* her mother. She illustrated this with explicit reference to Naledi's ART-taking: "She [Naledi] loves her treatment. She understands. She has learnt. She loves the treatment a lot. It's her mother who is bad at taking treatment. She throws them down the toilet. And that's why she got sick." Naledi's concerted treatment-taking was further contextualized with other examples of her obedience and contributions to homemaking: "She cleans, she cooks, she put in the tiles in the doorway." Through investments in the homestead, Naledi demonstrates that she is not her mother and works to mend the familial wounds related to her mother's scandalous absence.

During a clinic consultation in Ridgetown, Anele's grandmother referred to Anele's (age 13) recent struggles with pill-taking, describing this to a nurse as an instance of him "not listening to her." Here, adherence to ART was seen as a sign of respect to one's elders. Some adolescents similarly described ART-taking as a way to demonstrate deference towards their adult guardians. Xolani (age 11), for example, told us that he "loved" his pills, and when we asked why, he said, "Because *Makhulu* (Grandmother) tells me to take them."

Conversely, ART support from guardians was sometimes presented as a means of strengthening intergenerational reciprocity. For example, during afternoon tea one day, we asked Bongani whether he knew his mother. He described how she lived in "Area 6" of the township. Sometimes he bumped into her on the street and people would tell him, "That's your mom." At other times, she would call

and ask why he did not visit. He replied: "I am always busy at school and you don't do anything for me." In contrast to the distant relationship he described with his mother, Bongani later told us that his relationship with his aunt was "good": she made sure he took his pills on time, sometimes coming to fetch him if he was out late playing.

Also citing ART-support and reciprocity as evidence of 'good relationships,' Anele (age 13) described his relationship with his grandmother as very good because he made tea for her, and in return, she helped him with his medication. Nina (age 14) said her relationship with her grandmother was good "because she checks whether I have taken my pills." Both ART-taking and ART support are signified as reciprocally important in nurturing intergenerational ties. Narratives that demonized mothers were appropriated to boost ART adherence, just as ART adherence was encouraged to instill obedience and intergenerational care. Appealing to familial relationships to encourage medication-taking may not be uncommon. Similarly, bolstering familial ties in the wake of maternal abandonment is not specific to families with adolescents on ART. What is novel among families under discussion here is that the tasks of treatment-taking and home-making were often intertwined, both seeming to pivot around the mythology of an absent mother.

Temporality and the ritual of ART

Although some families had inscribed on ART-taking a familiar ritual precedent, in which the troubles of the past might be attended to in the present, ART was a ritual only in the habitual sense; it formed part of the domestic rhythms of mutual caregiving and household maintenance—boiling water, baking bread, cooking, and cleaning. Through these mundane domestic rituals, adolescents and their elders practiced relatedness and reciprocity. At the same time, this regimen of ritual activity approximated social order, amid the profound uncertainties and fragilities of home.

White (2001) and Henderson (2012) have described how pre-existing ritual repertoires were mobilized to attend to new social ills like HIV/AIDS and joblessness. In this study, some families, and particularly some women, seemed to appropriate the comparatively new ritualized activity of ART-consumption for the re-instantiation of an imagined 'old' order of obligation, authority, and mutual care. The re-assertion of these values was sometimes articulated in a patriarchal idiom, which positioned mothers as the source of moral disintegration. ART might therefore work symbolically to bridge three distinct temporalities: the present-day consumption of a new biotechnology, the immediate past of dead and missing mothers, and an imagined 'traditional' past, characterized by obedience, discipline, and a commitment to the rituals of home. Here, ART is one means by which relatedness is practiced and constituted as a social reality, attending to the perceived deficiencies of contemporary life.

Conclusion

In this article, we have focused on an isolated moment in a much longer trajectory of chronic medication-taking for these adolescents.[1] Through familial narratives that demonize adolescents' missing mothers, the 'redemption' narratives typically associated with ART take new form, implying four possible modes of 'atonement.' First, adolescents are compelled to succeed at treatment where their mothers failed to take pills or did not have access to them. Second, by taking ART, adolescents were able suppress the virus and thereby gain mastery over their received maternal illness. Third, as ART-taking forms part of ritualized respect shown to one's elders, it also served to atone the 'deviant' mother through socially sanctioned behavior. By demonstrating obedience through ART, adolescents also showed gratitude for the care they were receiving, which, in contrast to their mother's purported neglect, 'saved' them from near death and secured them a better life. Finally, by promoting ART, grandparents might redeem their own parenting, protecting their grandchildren from the calamity that took their sons and daughters. By weaving narratives of lost mothers and

ART-taking practice, families in this study sought to reinscribe relationships of care, obligation, and indebtedness.

Note

1. As different social groupings or networks of belonging take prominence for adolescents in this study, narratives that situate ART-taking as a family obligation may not be as powerful.

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Notes on contributors

Beth Vale is a DPhil candidate in the Department of Social Policy and Intervention at the University of Oxford, with a Masters in Sociology from the University of Cape Town.

Mildred Thabeng is a social work student at the University of South Africa and a research assistant on the *Mzantsi Wakho* study.

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