

AUTHOR:

Themba Dube¹, Lecturer

AFFILIATION:

¹History Department,
Stellenbosch University

EMAIL:

tdube01@sun.ac.za.

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HIV/AIDS, WOMEN'S MIGRATION FROM PLUMTREE TO JOHANNESBURG, AND CHANGING PERCEPTIONS ABOUT DISEASE AND THE DISEASED, 1995-2006

ABSTRACT

This paper seeks to show how migration of the women from Plumtree district to Johannesburg between 1995 and 2006 shaped the spread of HIV/AIDS disease. The focus of this study is twofold: (1) to outline how the migration of women from rural Plumtree exposed them to HIV transmission beginning from their journey to Johannesburg, and (2) to understand societal perceptions on women who had HIV/AIDS. The paper also highlights how the terminology used in different epochs illustrate the changing perceptions about disease and the diseased women between 1995 and 2006. By so doing, the paper engages with the language used reflecting on the interface of women's migration, with HIV/AIDS. Above all, the paper contributes to the literature on migration, women and HIV and opines that although migration has a negative impact on both men and women who leave their countries of origin, women suffer more and this is also complicated by the HIV/AIDS disease. The paper uses secondary sources and draws from life history interviews conducted with undocumented migrant women from Plumtree district who live (d) and work(ed) in Johannesburg to explore the lives of these migrant women living with HIV/AIDS.

Keywords: *Women, HIV/AIDS, Perception, Plumtree, Malayitsha, Johannesburg, Undocumented migrants*



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1. INTRODUCTION AND BACKGROUND

In 2018, UNAIDS estimated that 37.9 million people globally were living with Human Immunodeficiency

Virus (HIV).¹ The explosion of HIV/Acquired Immuno Deficiency Syndrome (AIDS) in Southern Africa makes it Africa's most threatened region, medically, socially and economically. The epidemic has from the outset been a battle of ideas as much as a battle about bodies and organisms and cells.² The connection between migration and HIV/AIDS has been explored extensively, and it has been established that the social disruption that accompanies migration is a crucial mediating factor in this relationship.³ By using the case of undocumented migrant women from Plumtree, living with HIV/AIDS, working in Johannesburg, the paper seeks to show the intersection of migration, HIV /AIDS and gender.⁴ It opines that these undocumented women were exposed to the disease from the beginning of their journey, and further illustrates the challenges of living with the disease in Johannesburg. Lastly, the paper engages with how perceptions of the disease and the diseased changed between 1995 and 2006.

In order to engage with these perceptions, the paper explores linguistic discourses around these women embodied in various phrases and expressions. As such, the paper uses discourse analysis which considers how language, both spoken and written, enacts social and cultural perspectives and identities. As Sara Shaw and Julia Bailey argue, discourse analysis involves looking beyond the literal meaning of language, understanding the context in which social interaction takes place and exploring what was said, when and why.⁵ Discourse analysis, therefore, brings a different lens through which

1 <https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data>, accessed 14 March 2019.

2 JE Cameron, "Opening address for AIDS in context conference", University of the Witwatersrand. 4-7 April 2001.

3 Examples of this literature include, C Campbell and B Williams, "Beyond the biomedical and behavioral: towards an integrated approach to HIV prevention in the Southern African mining industry", *Social Science and Medicine* (48), 1999, pp. 1625–1639; J Decosas *et al.*, "Migration and AIDS", *Lancet* (346), 1995, pp. 826–828; J Decosas and A Adrien, "Migration and HIV/AIDS", 11 (Suppl A), 1997, pp. 77–84; K Jochelson, *et al.*, "Human Immunodeficiency Virus and migrant labor in South Africa", *International Journal of Health Services* (21), 1991, pp. 157– 173; M Lurie, "Migration and AIDS in Southern Africa: A Review", *South African Journal of Science* (96), 2000, pp. 343–355; J Crush and G Tawodzera "Medical xenophobia and Zimbabwean migrant access to public health services in South Africa", *Journal of Ethnic and Migration Studies* 40 (4), 2014, pp. 655–70; C Campbell, "Migrancy, masculine identities and AIDS: The psychosocial context of HIV transmission on the South African gold mines", *Social Science and Medicine* 45 (2) 1997, pp. 273-281.

4 For the purposes of this study, undocumented migrant women are defined as those with no documentation allowing them to legally stay in the host country, South Africa The paper focusses only on those women that accessed their treatment from their country origin (Zimbabwe) mainly due to fear of deportation and problems of documentation and police harassment

5 SE Shaw and J Bailey, "Discourse Analysis: What is it and Why is it Relevant to Family Practice?", *Family Practice* (26), 2009, p. 417.

we can potentially add to and deepen our understanding of the connection between women migration and HIV/AIDS. The study, therefore, presents these women as transnational and demonstrates the role of the HIV/AIDS disease in shaping the lives of these undocumented migrant women. Against this background, the purpose of this study is to explore the intersection of women migration, the spread of the HIV/AIDS and the societal perceptions about the migrant women from Plumtree living with HIV/AIDS in Johannesburg.

There is vast literature on migration and spread of HIV/AIDS, with migration noted as the structural driver of HIV.⁶ Studies have also tackled the issue of migrants and their access to treatment, thereby raising questions of stigma and treatment continuity.⁷ Other studies have looked at the challenges faced by migrants living in South Africa and their difficulties in accessing Anti-Retroviral Therapy (ART). In particular, studies have also focussed on the feminisation of migration and the link between migration and HIV/AIDS amongst Zimbabwean migrants living in South Africa.⁸ Carolyn Sargent and Stephanie Larchanche also reiterate that globally migrants are marginalised, and this places them at risk of not accessing treatment.⁹ Joanna Vearey argues that current health-system planning within South Africa does not adequately address the health of migrants when they are in urban and peri-urban areas, forcing them to move back home should they become too sick to work.¹⁰ On the contrary, some studies have argued that migrants choose

- 6 KE Zuma *et al.*, "Risk factors for HIV infection among women in Carletonville, South Africa: Migration, demography and sexually transmitted diseases", *International Journal of STD and AIDS* 14 (12), 2004, pp. 814–817; SS Abdool Karim *et al.*, "Integration of antiretroviral therapy with tuberculosis treatment", *New England Journal of Medicine* 365 (16), 2011, pp. 1492–1501.
- 7 J Vearey, "Migration, access to ART, and survivalist livelihood strategies in Johannesburg", *African Journal of AIDS Research* 7(3), 2008, pp. 361-374; J Vearey, "Migration and health in South Africa: implications for development". In: A Segatti, and L Landau (eds.), *Contemporary migration to South Africa: A Regional Development Issue. World Bank and AFD* (Washington DC: The World Bank, 2011); J Vearey and MW Solomon, Migration issue brief #9. *Deportation and Public Health: Concerns around the Ending of the Zimbabwean Documentation Process*, 2011, pp. 1-15.
- 8 See, Decosas, *et al.*, "Migration and AIDS", pp. 826–828; S Sen *et al.*, "Migration, poverty, and risk of HIV infection: An application of social capital theory", *Journal of Human Behavior in the Social Environment* 20 (7), 2010, pp. 897-908; Decosas and Adrien, "Migration and HIV/AIDS"; S Sen and JP Aguilar, "HIV/AIDS and Migration in Sub-Saharan Africa". In: Q Xu and LP Jordan (eds.), *Migrant Workers, Social Identity Occupational Challenges and Health Practices* (New York: Nova Science Publishers Inc., 2016); P Munyewende *et al.*, "Exploring perceptions of HIV risk and health service access among Zimbabwean migrant women in Johannesburg: A gap in health policy in South Africa", *Journal of Public Health Policy* 32 (1), 2011, pp. 152-161.
- 9 C Sargent and S Larchanche, "Transnational migration and global health", *The Production and Management of Risk, Illness, and Access to Care* 40 (1), pp. 345-361.
- 10 Vearey, "Migration, access to ART, and survivalist livelihood strategies in Johannesburg", pp. 361-374.

to access ART treatment from their countries of origin and not necessarily on being discriminated in the host countries. Nedson Pophiwa explored the dynamics of health care utilisation patterns of Zimbabwean migrants residing in Johannesburg, South Africa and elaborated on factors which determine the utilisation of public health facilities by Zimbabwean migrants.¹¹ In addition to the above, Kudakwashe Vanyoro in a study conducted in Musina, argues that “despite several institutional and policy-related challenges, frontline health care providers in Musina provided public health care services and HIV treatment to black African migrants who are often at the receiving end of xenophobic sentiment and violence”.¹² This paper opines that the choice to access treatment in Plumtree by these undocumented migrant women was motivated by their undocumented status as they feared to go to health centres in South Africa for fear of deportation, although some expressed marginalisation by South African health services.

Focussing on migrants from the Matebeleland region, France Maphosa discusses some of the factors that expose migrants, particularly irregular migrants, to HIV infection as well as making them catalysts in its spread, both on transit and at the destination.¹³ The paper takes this further by exploring the lives of these migrant women, and the challenges they faced in Johannesburg and the changing societal perceptions about the disease and the diseased in Plumtree district. It also probes the vital role played by the *Malayitsha* system on the transmission of the disease during the beginning of the journey to Johannesburg. Tinashe Nyamunda explores the history and experiences of cross-border couriers/transporters known as *omalayitsha*, who remit money and commodities across the border between South Africa and Zimbabwe.¹⁴

11 N Pophiwa, Healthy migrants or health migrants? Accounting for the health care utilisation patterns of Zimbabwean migrants living in South Africa (MA, University of the Witwatersrand, 2009).

12 K Vanyoro, “When they come, we don’t send them back” : counter-narratives of “medical xenophobia” in South Africa’s public health care system”, *Palgrave Communications* 5 (101), 2019, pp. 1-12.

13 F Maphosa, “Irregular migration and vulnerability to HIV&AIDS: Some observations from Zimbabwe”, *Africa Development* 37 (2), 2012, pp. 119–135. Also see, M Giorgio *et al.*, “The relationship between social support, HIV serostatus and perceived likelihood of being HIV positive among self-settled female, foreign migrants in Cape Town, South Africa”, *Journal of Immigrant and Minority Health* 19 (4), 2017, pp. 883-890.

14 T Nyamunda, “Cross-Border couriers as symbols of regional grievance? The Malayitsha remittance system in Matabeleland, Zimbabwe”, *African Diaspora* (7), 2014, pp.38–62. For more on the Malayitsha see also, X Tshabalala, *Hyanas of the Limpopo: The social politics of undocumented movement across South Africa’s border with Zimbabwe* (PhD, Linköping University, 2017); V Muzvidziwa, “Cross-border Traders: Emerging, Multiple and Shifting Identities”, *Alternation* 19 (1), 2012, pp. 217-238; P Nyoni, Malayitsha as informal remittance couriers: A case study of Zimbabwean remittance transporters (Malayishas) in central Johannesburg (MA, University of the Witwatersrand, 2011); V Thebe, “From South

While his focus is on remittances, this paper looks at *Malayitsha's* role in the spread of HIV/AIDS, during the transportation of women from Plumtree. The paper seeks to contribute to this growing body of literature by linking migration, women, HIV/AIDS and the societal perceptions on disease and the diseased undocumented migrant women from Plumtree district.¹⁵

The study utilised 20 undocumented migrant women (also living with HIV/AIDS) aged 20 to 35 who lived in Johannesburg between 1995 and 2006. All the women interviewed were working as domestic workers. As the study sought to engage with these undocumented migrant women living with HIV/AIDS, I employed a Purposive Sampling Technique (PST) as a tool for selecting participants. Dolores Tongco defines it as a thoughtful selection of a participant based on the qualities that a participant has.¹⁶ PST enabled me to identify and recruit suitable informants based on defined qualities.

In-depth semi-structured interviews were the core qualitative technique that was used to gather data around the Beria, Hilbrow and Yeoville in Johannesburg. Life history interviews were conducted with undocumented migrant women from Plumtree living in Johannesburg to capture the unique characteristics of this group of migrants, enquiring about their own experiences and societal perceptions of HIV/AIDS. The women were chosen to represent the difficulties faced by undocumented migrant women migrating from the rural areas of Zimbabwe. Their encounter with various forms of risks that expose them to the HIV/AIDS pandemic from the beginning of the journey to South Africa is critical in understanding the gendered problems associated with migration. In most cases, women's first encounter with urban life and its challenges was in Johannesburg. Some women were widowed while some were divorcees with their roots in the rural areas of Plumtree.¹⁷ These life-history interviews provided a window into the life goals, priorities, and pathways of these women. Although life history interviews were vital, there were some limitations that were encountered during the interviewing process. At times it was difficult for some women to remember their journeys into Johannesburg, due to distorted memory. Moreover, some were sceptical, and it took time to

Africa with love: The malayitsha system and Ndebele households' quest for livelihood reconstruction in south-western Zimbabwe", *Journal of Modern African Studies* 49 (4), 2011, pp. 647-670.

15 Plumtree is a district which comprises Bullima and Mangwe, situated in the south-western parts of Zimbabwe. Geographically it lies in region five, which is a drier part of the country. The Kalanga ethnic group is the dominant ethnic group although there are other ethnic groups such as Tswana, Ndebele, Shona and Sotho among others.

16 DC Tongco, "Purposive sampling as a tool for informant selection", *Ethobotany Research and Application* (5), 2007, pp. 147-158.

17 This was revealed by one of the respondents. Interview: Author with M Moyo, Hilbrow, Johannesburg, 16 July, 2014.

establish trust. In order to overcome these limitations, I interviewed 20 women to capture different voices. Since all of the participants interviewed in the paper were undocumented migrants, I took precautions to ensure that confidence among them was gained and that there were no risks of exposing them. As such, the paper uses pseudonyms rather than their actual names. Although I rely much on interviews with the undocumented migrant women, I draw from a broad range of literature to overcome bias and to nuance my analysis of these women's migrant life experiences.

The period 1995 was purposefully selected as it marked the rise of Plumtree female migration to Johannesburg, which also coincided with the spread of the HIV/AIDS pandemic. The study ends in 2006 when most people in Zimbabwe suffering from the disease had access to free (ART). Ultimately, the paper addresses the following questions; (1) How did the migration process contribute to migrant women's HIV/AIDS status? (2) What are the challenges faced by undocumented migrant women in the era of HIV/AIDS? (3) How did societal views on these women change between 1995 and 2006?

2. FROM WITCHCRAFT TO A "WOMAN'S DISEASE": THE UNDERSTANDING OF HIV/AIDS PANDEMIC AMONGST THE PEOPLE OF PLUMTREE.

Migration by Africans from within the Southern African region into South Africa has deep historical roots dating back to the precolonial era. Xolani Tshabalala alludes to this movement of people and asserts that "the Southern African region in which the Limpopo Valley sits has been, for as long as contemporary historians can recall, a region of constant movement".¹⁸ This long interaction and movement across the region has a long history. As Pophiwa argues, "it is beyond doubt that these migration patterns have been produced, influenced and shaped by different events throughout history from the time of *Mfecane* through to the advent of colonialism and the present post-colonial dispensation".¹⁹ The cross border movement is also well captured by Francis Musoni who historicises the dynamics of cross border movement that evaded official measures of control of migration from colonial and post-colonial Zimbabwe to South Africa.²⁰

Consequently, the discovery of gold in Witwatersrand in 1886 and of diamonds in Kimberley in 1867 led to an increase in the migration of people

18 Tshabalala, *Hyanas of Limpopo*, p. 42.

19 Pophiwa, *Healthy migrants or health migrants?*, p. 10.

20 F Musoni, *Border Jumping and Migration Control in Southern Africa* (Bloomington: Indiana University Press, 2020).

from the north of the Limpopo River into South Africa.²¹ Zimbabweans also comprised the group of Africans from the Southern African region who sought employment in these mines and cane fields in Natal. Until the 1960s, this migration to South Africa was male-dominated partly because mines demanded male labour and also due to restrictive colonial policies which denied female migration.²² However, over time women also started engaging in this cross border activity. As Pophiwa observes, "Zimbabwean women were increasingly engaging in cross-border trade as a survival strategy in neighbouring countries".²³ Although migration of Plumtree communities to Johannesburg had been a common phenomenon since the 1960s, most of the people who migrated were men. This was shared by Maria Moyo, who remarked, "At my village, in fact, the whole of Plumtree, women stayed at home while men travelled on foot to eGoli, (Johannesburg)".²⁴ Another interviewee also said "most of the men used "dabulaphu", (meaning travelled long distances on foot and used private transport until they reached Johannesburg) so no woman would do that".²⁵ Thus, during much of the latter half of the twentieth century, Plumtree men of reproductive age (approximately men aged 17 to 50) migrated to other parts of Zimbabwe and to South Africa pulled by diamond and coal mining industries.²⁶ Participation in migration, both within the country and to other parts of the region, was often an essential part of the life cycle for men. It was indeed part of the definition of personhood and usually entailing migrating for several years at a time before returning home.²⁷ This oscillatory migration exposed these men to sexually transmitted infections and other diseases.

Diseases have always been treated with suspicion in African societies. When HIV/AIDS emerged in Plumtree, (in the early 1990s) it was a disease associated with witchcraft. Migrants and their families attributed the diseases to witchcraft as they felt that their family members were be-witched because of their perceived affluence as a result of working in South Africa. To this effect, Nozithelo Malaba commented, "we had not seen such a disease, and we

21 F Wilson, *Labor in the South African gold mines 1911–1969* (Cambridge: Cambridge University Press, 1972).

22 See, Musoni, *Border Jumping and Migration Control in Southern Africa*; Pophiwa, *Healthy migrants or health migrants?*; Tshabalala, *Hyenas of Limpopo*; A Adepoju, *Family, population and development in Africa* (London: Zed Books, 1997).

23 Pophiwa, *Healthy migrants or health migrants?*, p. 10.

24 Interview: Author with M Moyo.

25 Interview: Author with H Nyathi, Alexander, Johannesburg, 31 January 2014.

26 For the history and pattern of this migration, see, L Zinyama *et al.*, "Guess who is coming for Dinner: Migration from Lesotho, Mozambique and Zimbabwe to South Africa", *International Migration Review* 34 (3), 2000, pp. 813-841; Wilson, *Labor in the South African gold mines 1911–1969*.

27 Zinyama, *et al* "Guess who is coming for dinner", pp. 813-841.

thought Mr Zitha Nkomo had been be-witched since he had a big house and was working in Johannesburg".²⁸ Thabani Lumphahla also echoed the witchcraft dynamic and said, "in most cases, it was well to do men working in South Africa who came back ill, and we all thought they were be-witched".²⁹ Sharing the same sentiments was Hloniphani Nyathi who said, "I remember it was in 1991 that two old women from my village were accused of be-witching Mr Nkunzi Dliwayo who came back from Johannesburg ill, it was later discovered that he had HIV".³⁰ The above articulations serve to illustrate how little the people from these areas knew about the disease and hence associated it with witchcraft. Furthermore, it indicates how the disease was linked with migration and the gendered dimension of that migration during that time.

Up to the present day, cases of premature death or untimely illnesses in Africa are almost attributed to the action of invisible forces, frequently those described as witchcraft. While there is a dominant global narrative with regards to AIDS as a sexually transmitted disease that kills, there are also multiple local narratives that situate definitions of the disease within local understandings of illness and misfortune.³¹ Witchcraft in the Zimbabwean context means the manipulation of powers inherent in people, spirit entities and substances to cause harm to others.³² There is an existence of burgeoning literature on witchcraft in Africa.³³ However, the meaning of witchcraft is beyond the scope of this study. The critical elements of the witchcraft paradigm are premised upon the conviction that suffering and misfortune are a sign of the action of the invisible power.³⁴ This paradigm was pushed in the early 1990s when the impact of HIV/AIDS disease began to be severely felt in Plumtree. Most of the affected were men who were working in Johannesburg as migrant labourers. Because the disease not yet known, it was associated with witchcraft as these migrant labourers were viewed to be of better financial standing. There was a common saying amongst those who returned to their communities sick. They usually said, *Ngifela impahla yami*, meaning (I am dying because of my property).³⁵ HIV/AIDS was, therefore associated with jealousy and witchcraft.

28 Interview: Author with N Malaba, Alexander, Johannesburg, 15 August 2014.

29 Interview: T Dube with T Lumphahla, Alexander, Johannesburg, 18 August 2014.

30 Interview: Author with H Nyathi.

31 HO Mogensen, "The Narrative of AIDS among the Tonga of Zambia", *Social Science and Medicine* 44 (4), 1997, pp. 431-439.

32 P Geschiere, *The Modernity of witchcraft* (London: University Press of Virginia, 1997).

33 P Geschiere, *The Modernity of witchcraft*; T Sanders, "Reconsidering Witchcraft: Postcolonial Africa and Analytic (Un)Certainties", *American Anthropologist* 105 (2) 2003, pp. 338-352; I Niehaus, "Cutting and connecting: "Afrinesian" perspectives on networks, relationality, and exchange", *Social Analysis: The International Journal of Anthropology* 57 (3), 2013, pp. 25-41.

34 Mogensen, "The Narrative of AIDS among the Tonga of Zambia".

35 Interview: Author with G Kulube, Berea, Johannesburg, 8 February 2014.

However, in most cases, these men were involved in a life of multiple sexual relationships in Johannesburg as a symbol of economic and social success and as a form of entertainment.³⁶ It did not necessarily mean that they were in love but that they belonged to a socio-economic class that was different from the rest of the society. They would have material resources, the knowledge of the social world outside their local communities, and the prestige associated with these. Their lifestyle of multiple sexual relationships was never interpreted as an indication of social irresponsibility and immorality, but as a symbol of economic and social success acquired through their migration to Johannesburg. This male dominance and behaviour dovetails neatly with the concept of hegemonic masculinities. Nicholas Davies and Gillian Eagle define hegemonic masculinity as “not a fixed character type, but rather the masculinity that occupies the dominant position in a given pattern of gender relations”.³⁷

Hegemonic masculinities were more pronounced when wives who cared for their sick husbands became ill. Because it was not common for women during the late 1980s to early 1990s, to work as migrant labourers in Johannesburg, they began to save as caregivers to the sick men in these communities. However, whenever any woman caregiver contracted HIV/AIDS and fell ill, she was often accused of having be-witched their husband and that sins from the past were haunting her.³⁸ Thus it can be seen how societal customs were at play around the perceptions on HIV/AIDS disease amongst the people of Plumtree district. These perceptions reinforce the witchcraft paradigm and how this was often blamed on women.

Women began to be involved in the migrant labour system in significant numbers from the mid-1990s. The economic hardships necessitated the migration of women to Johannesburg.³⁹ These hardships were exacerbated by the Economic Adjustment Programme (ESAP) of the 1990s. ESAP was funded by the International Monetary Fund (IMF) and World Bank (WB) and was meant to address the ailing economies of the third world countries. Zimbabwe's economy fared quite well in the first decade of independence (1980-1990). In 1991 the country adopted the ESAP as a result of declining

36 Interview: Author with G Kulube.

37 N Davies, and G Eagle, “Nowadays they say ... Adolescent peer counsellors appreciation of changes in the construction of masculinity”, *Pins* (35), 2007, p.55.

38 Interview: Author with S Ncube, Alexander, Johannesburg, 16 February 2014.

39 Interview: Author with N Nleya, Alexander, Johannesburg, 21 March 2014. This reason was also cited by other interviewees such as; Interview: Author with S Ncube; Interview: Author with H Ndiweni, Berea, Johannesburg, 15 July 2014; Interview: Author with S Ndiweni, Berea, Johannesburg, 15 July 2014.

economic, social services.⁴⁰ Between 1991 and 1995, Zimbabwe also experienced a series of drought. These factors forced many people to look for employment outside the country. People from Plumtree district were therefore also affected. This was further complicated by the fact that Plumtree lies in region five, which is a dry part of the country and prone to drought. It was out of this context that women from this area began to embark on the journey to South Africa, mostly to Johannesburg. To this effect, Rita Masuku commented, “I could not take it anymore; my children were suffering, I had to go to eGoli (Johannesburg) to feed my children”.⁴¹ Qedani Nxumalo also said, “I left my home in 1995 having suffered a lot due to the drought”.⁴² In the 1990s, women from Plumtree began seeking city jobs in noticeable numbers, mostly due to intensifying poverty. Because of limited knowledge of cities, elders were ill-equipped to advise their daughters about migration, which ostensibly diminished “traditional” elder authority. Women migration to Johannesburg coincided with the time when HIV/AIDS was a threat in Southern Africa.⁴³ Poverty, lack of employment opportunities and the search for a better livelihood were the principal reasons for the out-migration of Plumtree women to South Africa.

3. MALAYITSHA, “MASIHLALISANE”: THE RISK OF HIV/AIDS AMONG UNDOCUMENTED WOMEN MIGRANT LABOURERS AND DEBATING BEING HEALTHY

The name *Malayitsha* (one who carry heavy loads) refers to the transport operators who usually carry the goods and migrant labourers from South Africa to their homes in Zimbabwe. Their name is derived from how they pack the goods. Often, they overload their small trucks/ vehicles, and they carry all kinds of goods ranging from groceries to clothing, building material and furniture, among other things, hence the name *Malayitsha*.⁴⁴ The *Malayitsha* became popular, especially at the height of the Zimbabwean crisis in 2008 as the migrants used to send lots of goods back home. They are also known to ferry illegal migrants from other parts of Zimbabwe as well into Johannesburg.⁴⁵ Tshabalala defines *Malayitsha* as “individuals who do not just transport, but also negotiate the crossing of mainly undocumented

40 For more on ESAPs see, A Mlambo, *The Economic Structural Adjustment Programme: The case of Zimbabwe 1990-1995* (Harare: University of Zimbabwe Publications, 1997).

41 Interview: Author with R Masuku, Johannesburg, 15 August 2014.

42 Interview: Author with Q Nxumalo, Berea, Johannesburg, 17 August 2014.

43 For statistics on HIV/AIDS related death during this period, see UNAIDS Data, 2019.

44 Interview: Author with B Ndlovu, Hilbrow Johannesburg, 17 July 2014.

45 Interview: Author with M Moyo.

people and goods through the Beitbridge border regularly".⁴⁶ There have been reports of sexual abuse of women by the *Malayitshas* on their journey to Johannesburg.⁴⁷ Musoni brings to light the assaulting of the migrants during their journey in the hands of the *magumagama* (a bunch of criminals who rob and kill migrants who cross to South Africa via Limpopo River on foot) and *malayitsha* at the border which divides South Africa and Zimbabwe. He observed that "The *malayitsha* and *magumagama* often assaulted, raped and even killed travellers whom they interact with at the border zone".⁴⁸ While "on the road", women especially are vulnerable to exploitation and harassment, which can include sexual assault.⁴⁹ The women under study also shared about these sexual abuses, although they also confirmed that it was not all the *Malayitsha* who abuse women.⁵⁰ The majority of them experienced difficulties during the journey. Some travelled for days, crowded in the back of *Malayitsha* trucks without stopping to sleep or eat and with little water.

According to some testimonies, two women and three children died in 1996 due to the difficult conditions of the journey or the violence they encountered along the way.⁵¹ Nomusa Nleya and Owakhe Ngwenya described the pain and suffering that women underwent in 1996 as they crossed the Limpopo River on foot. They explained how they were often asked to cross the river at night and would be assisted by the people who were paid by *Malayitsha* called *Impisi* (hyenas).⁵² Tshabalala gives a nuanced view in his study of the Hyenas of Beitbridge. He uses the hyena metaphor to explain a variety of actors and practices that constitute the whole border crossings by *Malayitsha*. He argues that *Impisi* is a term popularised in the 2000s to refer to *Omalayitsha* who assist undocumented migrants in crossing the Limpopo River into South Africa.⁵³ However, along the way these women, while travelling with the *Impisi*, they could have encounter thugs called *Magumagumas* and could victimise them if the women failed to offer them some money. At times the

46 Tshabalala, *Hyenas of Limpopo*, p. 47. For more on definition and operations of *Malayitsha*, see, Nyamunda, "Cross-Border Couriers as Symbols of Regional Grievance?", pp.38–62; Maphosa, "Irregular migration and vulnerability to HIV&AIDS", pp. 119-135; Muzvidziwa, "Cross-border Traders: Emerging, Multiple and Shifting Identities", pp. 217-238; Nyoni, *Malayitsha as Informal Remittance Couriers*, 2011; Thebe, "From South Africa with love", pp. 647-670.

47 Interview: Author with M Moyo.

48 Musoni, *Border Jumping and Migration Control in Southern Africa*, p. 2.

49 International Organisation for Migration (IOM) *HIV/AIDS, Population mobility and migration in Southern Africa: Defining a research and policy agenda* (Geneva: International Organisation for Migration, Geneva, 2005).

50 This was highlighted by interviewees such as M Moyo, T Luphahla and Q Nxumalo.

51 Interview: Author with "Anon", Beria, Johannesburg, 2 February 2014.

52 Interview: Author with N Nleya; Interview: Author with O Ngwenya, Alexander, Johannesburg, 21 August 2014.

53 X Tshabalala, *Hynenas of Limpopo*, p. 203.

Impisi could not handle the *Magumagumas* who would always be in greater numbers than *Impisi*. Zenzele Zulu further articulated that women are at a higher risk when they encounter the *Magumaguma*'s as they cannot always run faster than their fellow male travellers.⁵⁴

As indicated earlier, studies that have focused on the migrant labourers and HIV/AIDS have tended to focus more on the spread of the disease when these migrant labourers reach their destinations.⁵⁵ On the contrary, this paper shows that these women are exposed to torture and the state of sickness right from the beginning of their journey until they reach their destination. For example, Luphahla postulated that she moved to Johannesburg in 2000 when she was only 19 years old. Coming from the rural areas of Plumtree, she did not have enough money to pay for her transport. She stated that she was detained at the house of this *Malayitsha* in Johannesburg for six months. During those months, she was forced to have sexual intercourse with him, and that is how she contracted the HIV/AIDS disease.⁵⁶ Eventually, she was evicted by *Malayitsha* from his house when she fell sick. The story of Luphahla serves to elaborate on how in the context of economic hardships, sexual violence has become endemic. In a context where male power is constructed around control over women, sexual violence has been used as an outlet for power and anger. It is indeed an expression of masculinities that determines the submission of women. However, one should be cautious of portraying these women as victims, as some women might have exploited their sexuality to be able to access protection and provision.

The undocumented migrant women usually find themselves in a situation where they have to cohabit with men as a survival strategy in a foreign city. *Masihlalisane* (cohabitation) is a term used to define the cohabitation between the people of the opposite sex that usually takes place amongst the immigrants in South Africa. In most cases, either one of the partners would be having a wife or a husband in their countries of origin. They indulge in cohabitation and the relationship in most cases is not recognised by the relatives of one of the two families or both sides; hence the term *masihlalisane*.⁵⁷ These relationships do not always last long, such that within five years, some women would have cohabited with at least six men. Approximately 75% of the women under study indicated that they had been involved in cohabitation, while 25% were

54 Interview: Author with Z Zulu, Hilbrow, Johannesburg, 06 February 2014. This was also reiterated by Moyo, Luphahla and Nleya, who attested to knowing women who had been victims.

55 See Crush and Tawodzera "Medical xenophobia and Zimbabwean migrant access to public health services in South Africa"; Pophiwa, Healthy migrants or health migrants"; Vanyoro, "When they come, we don't send them back".

56 Interview: Author with T Luphahla.

57 Interview: Author with M Moyo.

still cohabiting.⁵⁸ Moyo, for example, indicated that she had lived with at least ten men over eight years.⁵⁹ To a greater extent, the practice of *masihlalwane* exposed most women and men to HIV/AIDS. Moreover, young women who migrate for economic or educational purposes are likely to depend on men, who are usually older than them for financial support. Hence the financial dependency of young migrant women increases their vulnerability to casual relationships in the urban sexual market.⁶⁰

During the period under study, perceptions of the disease and illness amongst these migrant women from Plumtree differed from the medical definitions of being healthy. For example, the World Health Organisation has defined health as not only the absence of disease but also the presence of physical and mental health and social well-being.⁶¹ Such an enlarged notion of health implies that shelter, food, a dependable livelihood, education, and a sense of safety from sexual and physical violence within one's community, control over one's life, and equality are all elements of health and well-being. Most of the women interviewed expressed many ideas about being healthy and being unhealthy, and they shared a common understanding of being healthy. The example of such notions was the belief that being healthy is being free from the disease and especially the AIDS disease.⁶² Also, when asked how they choose their sexual partners, they argued that a healthy or unhealthy person could be seen. Moreover, these women believed that people infected with the HIV/AIDS look physically sick as they usually have symptoms such as red lips, sores around the mouth and very dark in complexion.⁶³ About 10% of women who were interviewed shared the same views about the ideas of being healthy and being unhealthy. These were of the age range from 20 to 25. Because of their definitions of a healthy person, most of them run a risk of cohabiting with an infected person who does not show those symptoms. This, therefore, jeopardises their negotiation when it comes to condom use. In light of the above, Luphahla said, "When it comes to condom use, some men do not want them, so one has to do what the man wants."⁶⁴ In the same vein, Nxumalo emphasised, "It is the man who decides

58 This was shared by all participants. All of the women interviewed were single, some widowed or divorced when they left for Johannesburg. So it is interesting to note that nearly all of them once cohabited with men. The majority indicated that they preferred to cohabit with men from Zimbabwe although 15% did not have any preferences.

59 Interview: Author with T Kheswa, Hilbrow, Johannesburg, 31 January 2014.

60 M Brockerhoff and AE. Biddlecom, "Migration, sexual behavior and the risk of HIV in Kenya", *International Migration Review* 33 (4), 1999, pp. 833-856.

61 D Raphael, "Health inequities in the United States: Prospects and solutions", *Journal of Public Health Policy* 21 (4), 2000, pp. 145-179.

62 Interview: Author with Kheswa; Interview: Author with M Moyo; Interview: Author with N Nleya.

63 Interview: Author with Kheswa.

64 Interview: Author with Luphahla.

whether we can use the condom or not, I cannot do so, sometimes I need money.”⁶⁵ Their lack of education also influenced their ideas of being healthy. Most of them would not have attained primary or secondary school education.

4. GO HOME OR DIE HERE: ACCESS TO HEALTH CARE AMONG THE MIGRANTS OF PLUMTREE IN JOHANNESBURG.

Urban centres in countries with brisk economic activities and stable economies, respectively, attract a lot of foreign visitors and migrant workers. These migrant workers have been found to play a significant role in the spread of HIV.⁶⁶ Many migrant workers with little or no knowledge on HIV/AIDS, have experienced family separations and easy access to sex services, leading to a high prevalence of Sexually Transmitted Infections (STIs) and HIV/AIDS. On arrival in the country of destination, violence and discrimination continue to be part of the lives of many women as they experience dual vulnerability to violence. This is primarily due to their status as women, reflecting gender inequalities existing in both origin and destination societies, as well as their status as foreigners. Scholars emphasise that migrant women are vulnerable to sexual harassment, coercion, and violence.⁶⁷ This trend can be seen especially with regards to women from Plumtree, most of whom came from impoverished backgrounds and with little if any educational qualifications. Their social integration in new settings was limited by their initial lack of education and professional experience.

The higher vulnerability of women to sexual abuse and violence also placed them at risk of STIs including HIV/AIDS, and a range of post-traumatic stress disorders associated with sexual violence. Central to understanding women’s vulnerability to HIV infection is their economic disempowerment.⁶⁸ Rape and sex work among migrant women are a key factor in the transmission of HIV/AIDS and sexually transmitted diseases. While women move to escape

65 Interview: Author with Nxumalo.

66 JK Kreiss *et al.*, “AIDS Virus in Nairobi prostitutes: Spread of the epidemic to East Africa”, *New England Journal of Medicine* (314), 1986, pp. 414-418.

67 R Jewkes and N Abrahams, “The Epidemiology of rape and sexual coercion in South Africa: An overview”, *Social Science and Medicine* (55), 2002, pp. 1231-1244. For a nuanced discussion on this see, N Romero-Daza, “Multiple sexual partners, migrant labor, and the makings for an epidemic: Knowledge and beliefs about AIDS among women in highland Lesotho”, *Human Organisation* 53(2), 1994, pp. 192-205; Q Abdool-Karim and J Frohlich, “Women try to protect themselves from HIV/AIDS in KwaZulu-Natal, South Africa”. In M Turshen (ed.), *African women’s health* (Trenton, Africa World Press, 2000); I Susser and Z Stein, “Culture, sexuality, and women’s agency in the prevention of HIV/AIDS in Southern Africa”, *American Journal of Public Health* 90 (7), 2000, pp. 1042-1048.

68 Z Hlatshwayo and J Stein, “Why HIV/AIDS brings the need for gender equality into focus”, *AIDS Bulletin* 6 (4), 1997, pp. 17-18.

economic deprivation, lack of education often restricts them to unskilled jobs such as commercial sex work, informal trading, agricultural labour, or domestic work.⁶⁹ In some cases, undocumented migrant women are forced into debts that must be paid off through sexual activities.

Forms of discrimination occur at several levels. Often, policies regulating entry, access to the labour market and public services result in de facto discrimination against undocumented migrant women. This is indeed true concerning access to legal recourse, social security, housing, education, health care, employment and other socio-economic opportunities, as well as a lack of security and protection from violence.⁷⁰ The result is usually the systematic disempowerment of migrant women, which further increases their vulnerability to the HIV/AIDS pandemic. To make it worse neither Zimbabwe nor South Africa, the receiving country for approximately 90% of Zimbabwean migrants, has ratified the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families.⁷¹ This evidence shows that both countries have no explicit obligations to migrants and their families. With a particular reference to South Africa, Loren Landau opines that "the South African's government fails to give to its policies effective protection as the practice on the ground, at clinic level, does not follow the legal legislations".⁷²

Lack of basic sanitation and public health services often compound the lack of health care services for these women. As such, undocumented migrant women from Plumtree experienced exclusion, especially from the health care providers in Johannesburg.⁷³ As a result of exclusion, xenophobic tendencies and discriminatory policies against migrants by the South African health service providers, most of these women sought treatment from their country of origin, Zimbabwe. The voices of women below reinforce this exclusion and their decisions to seek treatment from Zimbabwe. Nxumalo

69 International Organisation for Migration (IOM), *HIV/AIDS, population mobility and migration in Southern Africa*, p. 17.

70 For more on this see, K McCarthy *et al.*, "Good treatment outcomes among foreigners receiving antiretroviral therapy in Johannesburg, South Africa", *International Journal of STD & AIDS* (20), 2009, pp. 858-862; Vearey, "Migration, access to ART", pp. 361-374; LB Landau "Protection and dignity in Johannesburg: Shortcomings of South Africa's urban refugee policy" *Journal of Refugee Studies* 19 (3), 2006, pp. 308-327.

71 A Smith-Estelle and S Gruskin, "Vulnerability to HIV/STIs among rural Women from migrant communities in Nepal: A Health and human rights framework", *Reproductive Health Matters* 11 (22), 2003, pp. 142-151.

72 Landau, "Protection and dignity in Johannesburg", pp. 308-327. Also see, McCarthy *et al.*, "Good treatment outcomes among foreigners", pp. 858-862; Vearey, "Migration, access to ART", pp. 361-374.

73 Interview: Author with R Masuku; Interview: Author with H Ndiweni; Interview: Author with S Ndiweni; Interview: Author with Q Nxumalo.

said, “I could not go to the clinic because I was afraid of being ill-treated by the health staff there”.⁷⁴ In the same vein, Moyo emphasised, “As an undocumented migrant, I knew that I would not be treated at that clinic because they do not want foreigners”⁷⁵.

Furthermore, structural factors, such as severely restricted access to work authorisation for immigrants, expose undocumented workers to environments marked by poverty as well as harsh and underpaid work, which generally jeopardises their sexual health and well-being more. Once they find out that they are HIV positive, most go home to seek medical attention, hence the phrase, “go home or die here”.⁷⁶ On the contrary, some studies have indicated that South African health care providers do not discriminate against foreign nationals.⁷⁷ Nonetheless, women interviewed in this study, noted that the health care providers discriminated them. For example, Lupahlha commented that “we do not seek treatment from home because we want to, but because they don’t want us here”.⁷⁸

The undocumented women living with the disease commented that they were sometimes turned away by the medical practitioners at clinics and hospitals accusing them of being *Amakwerekwere* who spread the diseases to the local South Africans.⁷⁹ For example, Emma Nkiwane remarked, “I was very sick and weak and went to the clinic. Before the nurse attended to me, she asked me for a South African I.D. When I mentioned that I was not South African, immediately her attitude changed. She accused me of being a *Kwerekwere* spreading diseases. I never went back to that clinic again”.⁸⁰ Scholars such as Jonathan Crush and Godfrey Tawodzera call this kind of exclusion, medical xenophobia.⁸¹ They argue that medical xenophobia is deeply entrenched in the South African public health system despite being a fundamental breach of the country’s Constitution and Bill of Rights, international human rights obligations and the existence of professional codes

74 Interview: Author with Q Nxumalo.

75 Interview: Author with M Moyo.

76 According to Nkiwane the phrase refers to a situation where the migrants have to choose to go to their countries of origin to access treatment or to remain in South Africa without treatment and die.

77 Pophiwa, “Healthy migrants or health migrants”; Vanyoro, “When they come, we don’t send them back”, pp. 1-12.

78 Interview: Author with Lupahlha.

79 Interview: Author with EM Nkiwane, Yeoville, Johannesburg, 3 February 2014. *Amakwerekwere* have been defined as babblers or people who speak indecipherable languages.

80 Interview: Author with EM Nkiwane.

81 Crush and Tawodzera, “Medical Xenophobia”, pp. 655–670. For more on exclusion of migrants see, Munyewende *et al.*, “Exploring perceptions of HIV risk”; Vearey, “Migration, access to ART”, pp. 361–74; A Joseph and K Todrys, “Access to Antiretroviral Treatment for migrant populations in the Global South”, *Sur. Revista Internacional de Direitos Humanos* 6 (10), 2009, pp.162-187.

of ethics governing the treatment of patients.⁸² Labels ascribed to migrants result not only in describing them but also in creating identities that hosts find convenient and appropriate. Vearey argues that the current health-system planning within South Africa does not adequately address the health of migrants when they are in urban and peri-urban areas, thus forcing them to move back home should they become too sick to work.⁸³ Generally, these migrants often have limited access to health information, including about HIV/STI and sexuality in their languages. Some even feel discouraged to access health facilities because of fear of being fired or deported if their employers learn that they are ill.⁸⁴ About 19 women reported a perceived worsening of their health since migration began; only one woman thought her health has improved.⁸⁵ The reasons often cited included having less money to obtain health care, having less food or more deficient nutrition, and a heavier workload. To this effect, Nyathi said, "I thought my life would be better here. I cannot afford basic foodstuffs, it is sad."⁸⁶ Malaba also added that "I work as a domestic worker for 10 hours, my boss does not give me food, so I sacrifice the little I get for my children back home."⁸⁷ On the contrary, Kulube said that her life had significantly improved, "I have a big house at my homestead. I could not have managed to build it if I were at home."⁸⁸

5. CHANGING PERCEPTIONS: EVERYONE'S DISEASE, LIVING POSITIVE AND THE ANTI-RETROVIRAL TREATMENT

Before the early 2000s, access to ART was limited to the rich who could afford to buy the higher-priced medication. While men also faced some challenges in accessing treatment, women suffered more. This was because they were unemployed and lived in rural areas which did not have adequate healthcare facilities.⁸⁹ Once they fell ill, they were discriminated against. It was even worse with those women who were migrant labourers. There was a lot of stigma against women migrants returning from Johannesburg ill as they

82 Crush and Tawodzera, "Medical Xenophobia", pp. 655-670. Also see, G Zihindula *et al.*, "Lived experiences of democratic Republic of Congo refugees facing medical xenophobia in Durban, South Africa", *Journal of Asian and African Studies* 52 (4), 2015, pp. 458-470.

83 Vearey "Learning from HIV: Exploring migration and health in South Africa" *Global Public Health* (1), 2011, pp. 1-13.

84 See, I Harper and P Raman, "Less than human? Diaspora, disease and the question of citizenship", *International Migration* 46 (5), 2008, pp. 3-26.

85 Interview: Author with S Ndiweni.

86 Interview: Author with H Nyathi.

87 Interview: Author with N Malaba.

88 Interview: Author with G Kulube.

89 Interview: Author with H Ndiweni.

were dubbed “prostitutes and immoral”.⁹⁰ Therefore, women suffered from stigmatisation as well as from lack of medical care from the hospitals in their home country. The HIV/AIDS disease in this district came to be associated with migrants, especially women. They were called by derogative names, such as *amakhikhitha* (prostitutes) and *abangcolileyo* (the unclean).⁹¹ At times these women preferred to stay in South Africa during their illness for fear of being stigmatised back home.

In the same vein, the disease itself was noted as one of the most dangerous and the residents in the Plumtree district gave it various names. For example, HIV/AIDS was named *ithathakancane* (the one that takes slowly), *umkhuhlane* (thee disease), and *umaqethula* (the destroyer). These names were associated with the negative impact that the disease had on the human body. It was believed that there was no hope of surviving once one has been infected with the disease. The negative attitude towards migrant women who had the disease dominated the public sphere in Plumtree district, especially for the better part of the late 1990s to the early 2000s. This was so because most people who died were men and women who were migrant labourers in South Africa. Women became easily blamed because of the patriarchal nature of society. Women usually stayed at home while men worked in cities and towns. Thus women who partook in this migrant labour system were often associated with prostitution. These women were accused of bringing the diseases from Johannesburg and spreading it to Plumtree men in Zimbabwe. In the late 1990s, a lot of people in Zimbabwe died from the AIDS pandemic due to lack of medical health care institutions.⁹²

Moreover, the scope for institutional health care for people living with HIV/AIDS was limited both at the individual and the national level in Zimbabwe. Most individuals could not afford the cost of nursing care, and the state could not provide sufficient hospital beds for all people with HIV/AIDS in the country. The pressures of economic dependency, the disintegration of extended kinship ties, and the general fear of HIV/AIDS all militated against good care of people infected with the disease. This was more pronounced in these migrant women who ended up at times committing suicide because of being neglected by family members.⁹³ It was during a phase when the government and the non-governmental organisations were struggling to make the drugs available and affordable to the general people of Zimbabwe.

90 Interview: Author with H Ndiweni.

91 Interview: Author with Z Zulu.

92 RM Mtutu, “Redefining masculinity in the era of HIV/AIDS in Zimbabwe”, *Gender, Culture and Rights*, 2005, pp. 138-143.

93 H Ndiweni, recalled how her best friend committed suicide after discovering her HIV status.

It is therefore interesting to note how the migrant women's failure to afford the anti-retroviral drugs not only jeopardised their access to health care facilities but also had much to do with migration and its impact especially on female migrants from the rural areas. Their bodies were viewed as unclean, dirty and unhealthy.⁹⁴ In the same vein HIV/AIDS was not only seen as an illness but as death itself, such that some people from Plumtree wanted these migrant women to be thrown out somewhere very far from the community.⁹⁵ Moyo said, "It was in 1999 that I became very ill and went back home, no one wanted to touch me, I overheard an old man from the village commenting that people who bring Aids should be left to die. At that moment I wished if I could die; it hurt me".⁹⁶

Similarly, Xolisani Nkabinde also said, "we were seen as outcasts in our village".⁹⁷ Another interviewee also commented, "The late 1990s were difficult, people blamed us for the disease and often distanced themselves from us."⁹⁸ Furthermore, this also serves to illustrate how society degraded and violated female body. Yet, no negative naming was done to men who were also migrant workers and were infected with the disease.⁹⁹ Greater care and attention was rendered to men by their family members (who were usually women) who continued to argue that they were not infected with the disease but instead they blamed it on witchcraft.¹⁰⁰ Migrant women working in Johannesburg on the other hand came to be viewed as dangerous women who did not know how to use their bodies in a moral way. In the minds of the residents of Plumtree, Johannesburg was constructed as an evil place for women as it transformed them in negatives ways. Moreover, images of migrant women's bodies as one of disease and uncontrolled sexuality.¹⁰¹ It can be argued that these ideas emerged from patriarchal individuals whose ideas of moral and healthy women were influenced by the cultural conceptions of what a good wife and a good woman was.

In the early 2000s, the Zimbabwean government started providing free ART to poor people who were living with HIV/AIDS.¹⁰² Migrant women from Plumtree who live in South Africa have also benefited from the programmes

94 Interview: Author with S Ndiweni.

95 B Ndlovu commented that when she went home with her sister who was seriously ill, one villager noted that the cure for AIDS disease would be to quarantine those who had the disease and leave them to die at an isolated place.

96 Interview: Author with M Moyo.

97 Interview: Author with X Nkabinde, Alexander, Johannesburg, 21 August 2014.

98 Interview: Author with T Lupahlala.

99 Interview: Author with G Kulube.

100 Interview: Author with H Nyathi.

101 Interview: Author with H Nyathi.

102 See R Hayes and H Weiss, "Understanding HIV pandemic trends in Africa", *Science* 311 (5761), 2006, pp. 620-621.

that were designed by both the government and the Non-Governmental Organisations (NGOs) that seek to assist people living with HIV/AIDS. Community-Based Care (CBC) was implemented, and it complimented secondary and tertiary care, thereby assisting households in coping with the stress of caring for the terminally ill. Since then, HIV/AIDS has thus been transformed into a disease of outpatient care and the economic costs of this disease in the district rests mainly upon follow up and ART.

It suffices to say that since 2004 there has been a significant shift in terms of perceptions of the disease and the diseased amongst the people of Zimbabwe in general and those from Plumtree in particular. This can be attributed to the availability of medication to the people living with the disease and some counselling programmes offered by the government and NGOs to the communities in Zimbabwe. Moreover, this has been influenced by the fact that the disease has affected both men and women profoundly. This transformation was even more pronounced in the change of the derogatory names used to describe HIV/AIDS. The disease was no longer called by negative names, and neither was it viewed as a fatal illness.¹⁰³

Consequently, there is a belief among the undocumented migrant women that HIV/AIDS-related tuberculosis is better treated in Zimbabwean hospitals.¹⁰⁴ This is not a unique phenomenon as scholars have observed a similar pattern amongst migrants from Lesotho. For example, Iyiola Faturiyele argues that in a survey carried out by health practitioners, most patients preferred all treatment services to be rendered in Lesotho, as they perceive the treatment provided in South Africa to be different often less efficient or with more severe side effects.¹⁰⁵ Most of the undocumented migrant women from Plumtree thus receive their treatment from Zimbabwe. They usually go regularly to Plumtree District hospital for continual monitoring of drug and viral levels in the blood. The stigma has virtually disappeared to the extent that people now talk openly about their statuses.

The undocumented migrant women under study also noted this transformation during their visits at home. Qondani Ndlovu who had travelled to her homestead in Plumtree for a funeral was impressed by the positive attitude of the people of Plumtree towards those who were on ART.¹⁰⁶ The story of Ndlovu reveals such changing societal perceptions. She recalls one morning when two women, took a bucket full of water and put it outside

103 Interview: Author with H Nyathi; Interview: Author with EM Nkiwane; Interview: Author with S Ndiweni; Interview: Author with G Kulube.

104 Interview: Author with N Nxele, Beria, Johannesburg, 25 January 2014.

105 I Faturiyele *et al.*, "Access to HIV care and treatment for migrants between Lesotho and South Africa: A mixed methods study", *BMC Public Health* 18 (668), 2018, pp. 1-10.

106 Interview: Author with Q Ndlovu, Hilbrow, Johannesburg, 21 March 2014.

of a hut at a certain homestead. Immediately after that, she saw a queue of people fetching some water from the bucket with their cups. She took her cup and followed the line, thinking that there was some ritual that needed to be performed with the water from the bucket. Not knowing what to do with the water, she had to ask one woman who was close by, and she told her that it was time for them to take their anti-retroviral drugs. She was also on ART but was ashamed of disclosing her status. This incidence, according to her, was an eye-opener on how people's perceptions on the disease have been transformed amongst the residents of Plumtree.¹⁰⁷ Since Ndlovu incident, the disease has now been treated as an open secret to such an extent that the neighbours know the type of the anti-retroviral drugs that their fellow neighbours take.¹⁰⁸ Women from the district take turns to go collect each other's medication from Plumtree District Hospital.

Additionally, migrant women from the area who are based in Johannesburg send their prescriptions with *Malayitsha* so that they can bring their medication as they cannot afford to collect their medication every month. These women usually go back home every six months to their doctors so that they have continual monitoring of drug and viral levels in the blood.¹⁰⁹ As a positive development, *Malayitsha* also assists with transporting these women's anti-retroviral drugs from home to Johannesburg.

6. CONCLUSION.

While migration of people to cities has been central to the spread of HIV/AIDS in general, the paper shows how this migration is gendered and its effects, primarily on undocumented migrant women from rural areas. The case of the undocumented migrant women from Plumtree district living in Johannesburg illustrated how the migration process exposed these women to HIV and AIDS disease. By using the discourse analysis, the paper explored the changing societal views of the disease and the diseased, and how these views mutate between 1995 and 2006. Women's lived experiences illustrate how the specific issues of migration and the HIV/AIDS crisis at this individual level are connected to broader issues of gender. After drawing from life history interviews of 20 undocumented migrant women, the paper opined that there is an interface of women's migration with HIV/AIDS. It, therefore, emphasises the complex tradeoffs that migration entails for migrant women and how these are interpreted in the context of the literature on gender, migration, and HIV/AIDS.

107 Interview: Author with Q Ndlovu.

108 Interview: Author with with Q Ndlovu.

109 It should be noted that health workers insist that people should collect treatment for themselves although they are not strict on reinforcing this.