



## **“Yesterday is History, Tomorrow is a Mystery”: Dying in South African Frail Care**

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### **Abstract**

What happens when we die? This article explores answers to this question as posed to staff and residents of a frail care (nursing) home, run by a Christian women’s charitable organization in a small-town in South Africa. The religious, cultural, and racial diversity of staff and residents, along with their different medical understandings of declining health and death constellate expansive perceptions of dying and life after death. Staff and residents share certainty about the continuity of a soul or spirit after death through a Christian God, although precise locations and modes of egress for these spiritual entities are uncertain. Heaven and hell are not strongly defined nor taken for granted realities. A presentist, rather than historical, orientation strongly shapes both the rhythms of daily life and the end of life in the nursing home. While residents aim to find meaning in daily life, staff aim to find meaning in aiding residents in the final moments of life by being tenderly co-present. Overall, peoples’ perceptions of spatiotemporal transitions from life to the immediate after-life effectively complicate notions of immanence in the anthropology of morality, ethics, and religion. To use one informant’s terms, the end of life is “a mystery” which residents and staff engage in delicate orchestrations of care work.

*Keywords:* Dying; end-of-life; nursing home; temporality; immanence; South Africa

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## **“Yesterday is History, Tomorrow is a Mystery”: Dying in South African Frail Care**

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### **Introduction**

“Yesterday is history, tomorrow is a mystery, but today is a gift, and that is why it’s called the present” is a three-line poetic quip about time, often featured in greeting cards, daily journals, and motivational texts. I learned this saying in 2015 from an 87-year old white Afrikaner woman named Babsie. She was a “prayer warrior,” according to her roommate Tina and the staff of Withuis, a small-town South African “frail care” home in which they lived.<sup>1</sup> She and Tina resided in the wing designated for more independent and ambulatory residents, their room usually bathed in salmon and ochre hues cast by the sun through sheer curtains. When I stopped in to greet them after breakfast one Tuesday morning, Babsie told me:

Today I go by the strength of God. He’s helped me out in so many situations. You see, there was a time I was dying. Everyone here saw me.

Tina came in from their small porch to abet Babsie’s storytelling. Tina said that the nursing staff became concerned when Babsie’s breathing deteriorated one afternoon, saying “it wasn’t good.” The nurse on duty rounded up a driver and a staff caregiver, and they took Babsie to the nearest public hospital in one of the black-majority townships surrounding the small city that anchors the area. Babsie recounted an internal monologue she had at the hospital where she stayed for two days:

I asked to die. Just finish it. But He didn’t. He had a different plan for me. God has a plan for everything. If it is not your time, it is not your time; we have to go by what God says. When He is ready, then it’s your time.

Stories like this, ones that I collected from residents like Babsie and Tina, and the Withuis staff, foreground a cultural metaphysics of dying. From their stories we learn how people who live and work in a common institutionalized space, but occupy differently situated demographic and biosocial vantage points, understand and experience the process of dying, the ethics of witnessing that process, and the after lives of death. The quip of “yesterday is history, tomorrow is a mystery,” which others in the home told to me, helpfully conveys what I discerned to be a culturally specific way of experiencing time in the later years.

Studies in medical anthropology and the anthropology of aging show how experiences of time are shaped by myriad medical, ethical, and technological negotiations surrounding a person’s biosocial death (Leibing 2006). Despite the well-defined pathways for how life is supposed to end in institutional settings like hospitals or hospice, practical negotiations of treatment, caregiving, and decision-making lead people to experience death as an unsettled process.<sup>2</sup> This article considers how residents and staff

of this frail care home reckon with care and treatment protocols, embodied experiences of frailty, decline and senescence, and religious experiences and symbolism to make sense of this unsettled process. It argues that these factors are mutually influential and significant for each groups' moral aspirations and experiences of time itself. Death was a major and potential event that people faced in the frail care home. It is an event, I argue, that led people to foreground divine mysteries and presences as a primary temporal orientation at the end of their own and others' lives.

### **Immanence and imminence as times of dying**

My interest in the question "what happens when we die?" focuses on the "when," or the temporalities that shape perceptions of aging and dying. Fassin's (2013) comparative study of sentiments inspires my approach to delineate these varied perceptions in the home. Looking at diverse social groups in the same field site of post-apartheid South Africa, as well as France, Fassin explores the meanings of "resentment" and its Francophone variant of "ressentiment" as ideal types of moral and political sentiments. The latter emerges as a "reaction to historical facts, which generate an anthropological condition [that] victims of genocide, apartheid, or persecutions experience... It implies not primarily revenge but recognition. It signifies the impossibility to forget and the senselessness to forgive" (Fassin 2013, 260). In the cases he presents, peoples' perceptions of violence they experienced in the past are still shaped by their racialized and or alienated subject positions in the present, and these sentiments may coexist or transmute in the present as well.

This article explores these transmutations and the 'impossibility of forgetting' as memories of a life amid violence change or transform over time, first in aging-related physical or functional processes, and second in the social settings older individuals (and their caretakers) inhabit, such as institutional care facilities (rather than households in their communities). The phonetic resonance among the terms in Fassin's case lead me to similar hermeneutic detective work to clarify the meanings of terms we have for understanding time and temporal experience. I consider how temporal ambiguities surrounding the end of life gray the lines between "immanence" and "imminence," two concepts that may help explain peoples' perceptions of dying in this particular South African setting.

Imminence means something is about to happen or is overhanging. It refers more to an event or phenomenon in potentia rather than a parallel domain or reality. An imminent thing is not inherently negative (Canclini 2014), but is often culturally qualified as dangerous, threatening, or something at risk of emerging. Fear induced by imminent violence, as in the example of prolonged armed conflict in Colombia, can itself become a form of local cultural knowledge (Castellanos 2015). In contrast, immanence means something is already existing or inherent within something else. Immanence presupposes a separation between objects, realms, or times but that somehow one inhabits the other. For example, the past is immanent in the present. At the conjuncture of memory and history, the present is shaped by and echoes the past in peoples' experiences of landscapes, material culture, and their social relationships among these (Birth 2006).

Anthropologists of religion show a kind of conflation of imminence and immanence, where evil or millenarian events are understood to be both phenomena existing somewhere and also about to appear in the world, much to humans' detriment. In their ritual and symbolic actions, humans assure that divinity mitigates the risk of evil from eventually bursting open (Kaell and Hardin 2016; Kravel-Tovi and Bilu 2008). Turner (1982) showed how the religious spaces where symbolic or ritual action occurs is often also experienced by those actors therein as outside of the normal flow of time.<sup>2</sup> In contemporary Western social life, Judeo-Christian influences shape perceptions that divinity is already manifest in this world, rather than somehow separate from it; this latter state of being is defined as transcendence.

Taylor (2007, 549) argues that we perceptually behold an “immanent frame” through which we decide to believe (or not) in divinity, noting the frame is “‘spun’ in ways of openness and closure, which are often dominant in certain milieux.” In other words, openness or closure to possibilities for experiencing divinity life depends on cultural and sociopolitical context.

Taking cue from Lambek (2015, 129), understanding how we negotiate movement among varied spatiotemporal frames (including those of death and dying) requires a turn to ethics or morality; ethics, he argues, is “intrinsic” or immanent to all social interaction. This immanence is a “ground” from which ethics emerge in everyday practice and become evaluative cultural criteria for how we should act, especially in uncertain or difficult situations.<sup>3</sup> Mattingly (2018, 47-8) argues that people’s life narratives about uncertain conditions like illness and dying reveal their urges to overcome these conditions as well as overcoming the force of the ethical demands they face among their family and caregivers. This dynamic is what Mattingly calls “immanent transcendence.” For her, ethical negotiations about overcoming these conditions are embedded and play out in narratives about their lives.

Narrative, then, is what people use in health care settings to existentially and socially move through these conditions and time itself.<sup>4</sup> Narrative or stories are thus key expressive media for identifying cultural and ethical experiences of time, aging, and dying in late life. They are accessible in the methods of interviewing and conversation that constitute this ethnography. Stories like Babsie’s are evidence of these experiences and offer a different perspective of older adults and their caregivers than previously focused on.

Els van Dongen was one the last anthropologists to do ethnographic research on South African older adults’ religiosity and meanings of aging. In one of her last, posthumously published chapters, based on time spent with impoverished black older adults living in peri-urban township communities, she argued that “religion and spirituality are not only medicine for the many traumas older persons have had and have to endure in their lives, but also that they are the means for survival”; religion was a “medicine and moral strategy” for abating their historically conditioned “misery,” and it positively impacted their “‘successful ageing’ and well-being” (Van Dongen 2010, 153). More recently, Douglas Bafford (2019) finds that older white South African evangelicals’ reflections on their country’s racist past (and their role in antiapartheid struggles) are heightened in retirement and morally converge with their millenarian preparations.

These findings open us to expansive visions or evaluative criteria of aging, dying, and temporality that older adults and their caregivers perceive, and how their aging-related and spiritual experiences reflect their historic and institutional setting. Taken altogether ethnographically, the diverse vantage points of residents and staff collapse presumed distinctions between past, present, and future, life and after-life, alertness and diminished cognitive functioning, and body and spirit. Settling in-between these reveals meanings and experiences of death’s “mysteries” that people often focused on, sometimes more so than the violent history of apartheid that also shaped where and who they are today. Following a discussion of methods and the field site, I trace a path through the opening poem that inspired the title of this article to situate the temporalities that devised life in the home.

### **Ethnography at the home**

Withuis is near Kruger Park in the Mpumalanga Province in the eastern part of South Africa. It was established in the 1950s amid strong white nationalist social welfare policymaking and is part of a larger network of facilities run by an Afrikaner Christian women’s charitable organization. The organization

itself was founded in the 1900s amid British and Afrikaner settler colonists' encroachment on indigenous African polities and wars among these groups.

Withuis is racially and demographically comparable to other residential frail care or old age homes nationally (Makoni 1998; Coetzee 1999; Sagner 2000; Van Dongen and Ferreira 2004). Administrators and the majority of lead nurses were white women. The staff of nursing aides, caregivers, cooks, and others were almost all black women. At the times of the research, out of the 50 majority women residents, three were black. Given such homes are historically white or racially segregated caregiving spaces, people in the home saw this racial arrangement as novel. Most people in the home were variably multilingual in English, Afrikaans, siSwati, or Xitsonga. Nearly everyone identified as Christian of some kind, as evidenced in statements about experiences of divinity and participation in daily prayers and weekly worship service programming. One black caregiver identified as Christian and also trained to be a sangoma (diviner)..

The majority of residents belonged to an age cohort born roughly between 1930-1940. The nurses were about 20-25 years junior to most residents, and the caregiving staff members were all born between the 1970s-1990s. About two-thirds of the residents had grown up, lived, or raised families within a three hour-drive of the home, and another third were living in the home as a result of their adult children, who had moved to the area and placed them there. Many white residents were middle to lower-class when occupationally active, identifying as having been housewives, farmers, or entrepreneurs. A few were party to more extreme activities. For example, one white male resident claimed to have been an officer assisting in state executions, and another white woman operated radios for the former white minority Rhodesian Security Forces. Most black residents I met were migrant indigents from neighboring countries of Eswatini and Mozambique, who were put into the home through the help of local black social workers; one black woman resident was moved there by her adult daughter. Nearly all the residents had been living in the home for less than seven years.

Three human ethics research boards approved interviews and or conversations with staff and residents and participant-observation at the home and others in its network. I conducted 20-30 hours per week of research from February-June 2015 and August-October 2019 and visited for two days in May 2017. Also, for two weeks in 2019, I was aided by a young Afrikaans-speaking woman research assistant, who fluently interacted with residents who primarily spoke Afrikaans. Withuis grouped residents into three wings based on their physical and cognitive faculties, including a wing that staff informally called the "Alzheimer's" wing that houses those living with more pronounced dementia, are extremely frail, or are behaviorally unsociable. I also conducted life history interviews with a dozen staff and residents not living with dementia. During participant-observation, I also engaged in ongoing conversation with staff and many residents, including those in the "Alzheimer's" wing. My findings, presented in three sections like the opening poem, show their perceptions of dying as shaped by race, gender, age, and cognitive function, as well as the shared work-life space they inhabited on a daily basis.<sup>5</sup>

### **Yesterday is history**

The first part of this poem offers an equivalency of two past times. The recency of the day before today disintegrates into a deeper temporal expanse. What distinguishes each is chronological, one by mere hours and the other a flush of years. Yet, each specially shapes how people in the home come to narrate their aging selves into the past (Myerhoff 1992).

A frail care home, in a postcolonial setting marked by a history of violence, is a complicated place to investigate peoples' sense of the past. First, for residents, many of whom lived with various stages of

dementia or frailty, the conjuncture of memory and communicative abilities was sometimes fragile. Physically and psychologically, it was difficult to talk, or talk at length about the past, which was a dynamic subject to ongoing negotiation, consent, and assent in the context of research and daily interaction with others in the home.

Many residents told me they did not remember what had happened the day or week prior, attributing forgetting to the mundanity of everyday life. Sitting over a breakfast of maize meal porridge with white women residents Jo and Vern in 2015, Vern told me, “when you get old, you give up more and more.” Asking her what it was that one gives up, she replied, “well, memories I think,” elaborating that the older one becomes, the more memories one beholds, and this becomes too much to remember as kind of a cognitive overload. In 2019, my research assistant wrote in her field notes about a conversation with a white woman resident named Jess, who “struggled to remember most of the finer details of her experiences with her family; however, she suspected that perhaps she’s ‘too lazy to think.’” In a conversation with three black kitchen staff women in 2015, they noted that many residents grew up during apartheid, and perhaps “do not know what is going on outside [of the home or in the country on national level]; “they might remember things from the past, but not remember what is happening today; they forget recent memories.”

Indeed, a special narrative element with respect to history were stories some individuals consistently retold about significant past events; this behavioral repetition may also be a sign of dementia or Alzheimer’s. For example, then-82 year-old Martina, a former housewife who came to live in the home at the end of my research in 2015, told me little about her past other than beholding a transformative divine vision in 1970. Trembling near tears each of the four times she recounted it to me over the course of two weeks, the experience left her feeling “like I was a child because He is so awesome. God is so awesome. I asked him to show me a verse and he led me to Proverbs 3: 5-6” — “trust in the Lord with all your heart, and lean not on your own understanding; in all your ways submit to him, and he will make your paths straight.” After this, Martina would then ask me when I myself had come to “know Jesus.” “I came to this place by God’s will,” she elaborated once, referring to Withuis, “God has a plan for me, just like he has a plan for everyone else.”

Martina’s narratives show how she derived strength from her historic relation with God and His divine providence. The bible verse about submission may also account for a life trajectory that is not uncommon to many South Africans. Like other postcolonial societies, the country’s history of colonial atrocities and enduring structural conditions of inequality engender and forcefully shape memories, identities, and relations among social groups. The residents altogether grew up during the start of the most egregious period of segregationist policymaking in the 1940s. They reached young and middle adulthood in the 1960s-70s to see high-apartheid infrastructural development in urban areas and forced segregation in the Group Areas Act, as well as the eventual decay of this system through the mass resistance movements of the late 1970s and 1980s (Crapanzano 1985). Most were in their 60s-70s at the end of Nationalist Party rule in 1994 with Nelson Mandela’s election to the Presidency.

For those who lived through the violence and paternalism of apartheid, submission, rather than resistance to the state or participation in its policies cultivated a subjugated life, but one in which individuals could remain alive, rather than imprisoned, or worse. The immensity of past violence, which included terrorism and killings, made history and one’s place in it distressing topics of discussion. This was clear in the ways both black and white staff generally avoided talking about historic tumult, believed in present redress for past wrongs, and waxed nostalgic for a past they perceived as more secure than the present.

For example, the white, head nursing staff often blamed the state of the contemporary public health care sector and society at large as due to (black) politicians' neglect. The white former head nurse told me in 2015 that (black) public hospital staff "do not care for the patients or their work; it is not like in the past when we would go there." Her perception of poor conditions at these hospitals also factored into decisions to triage patients (or not) like the prayer warrior Babsie and upheld a view that apartheid's (segregated) public health sector was superior. That same year, 2015, South African university students and others were engaging in a mass movement protesting tuition increases and changing educational policies as a mode of decolonization. First called "RhodesMustFall," the movements involved taking down campus statues of colonialist figures like Cecil Rhodes. In a conversation with a group of four black women caregivers, one told me, "we don't like the issue with the statues either; those [statues] make the cities look nice; Mandela told us in 1994 that we are one nation; they are being crazy over a statue that means nothing." I suggested to them the statues were a sore reminder of a violent history, to which one caregiver replied adamantly, "that's not it because there are lots of other statues of blacks like Sara Baartman [an infamously enslaved indigenous woman, b. 1789 - d. 1815] and Chris Hani [a black anti-apartheid activist, b. 1942 - d. 1993]; it's all in their minds."

This is not to say black staff members did not see racism operating in their midst; they did, often in dealing with angry, confused residents who made racist remarks toward them. Yet, revisiting the past seemed moot. More broadly, narrating one's place into the country's tortuous political past has been an ambivalent project. From 1995-1998, the Truth and Reconciliation Commission, a nationally televised restorative justice forum, tried to usher citizens beyond the violence of apartheid through public testimonies. Despite these efforts, many black South Africans found this to be inconsequential or incapable of culturally conveying their experiences of suffering in the form of self-referential, individuated narratives (Krog, Mpolweni, and Ratele 2009; Makoni 2008). In the few instances where black staff and white residents talked openly among each other about apartheid or the history of colonialism, these quickly transformed into joking situations, sacrificing personal or political standpoints for a necessity to be amicable as part of their role in the caregiving-resident relationship (Golomski 2020).

The exigencies of caregiving meant there was a lot of work to do. Staff did of course get to know the residents by constructing a shorter biopic of their past lives, asking: are or were they married, do they have children, what was their past occupation, and where are they from? These bits of information were crucial for interpersonal connection, but there was often little biographical depth beyond this. Staff primarily talked with residents in the context of aiding them with activities of daily living—bathing, feeding, clothing, toileting, transferring—and talked about the caregiving task at hand. In other words, they were not trying to talk about a past beyond yesterday when getting to the toilet; they were talking together about how to get to the toilet safely, comfortably, and with dignity.

While a few residents divulged intimate personal histories, which I explore in other writings, the daily, monotonous routines of treatments, meals, and interactions more strongly contoured an overall temporal preoccupation with the present. For residents at least, their varied historical experiences were more silently remembered and increasingly forgotten. Or perhaps because the past was so traumatic for some, there was no incentive to disturb anyone by bringing it up in a context of illness, frailty, and bodily intimacy. This is not to be an apologist for the older adults' racism or explain away some staff members' ambivalence toward history. Life history narratives and popular or historic explanations of violence are more entangled with or constitutive of each other (Argenti and Schramm 2012). This is rather to acknowledge that biomedical and humanitarian logics of elder care may structure social relations in ways that depoliticize history or dehistoricize livelihoods at the end of life.

## Tomorrow is a mystery

The most obvious future that residents and staff immediately faced was the residents' deaths. Of course, some residents were more likely than others to succumb to declining health, but the general sentiment was that, in the words of a hospice consultant I met there, Withuis was "God's waiting room."<sup>6</sup> If the next passage in residents' lives was death, what lie beyond this "room" was a spiritual mystery.

Many staff members told me about the process of "getting used" to death. This meant both witnessing the moment of death and working socio-culturally and emotionally through the aftermath, as well as learning how to handle death through specific institutional protocols. Despite its routine occurrence, staff told me it was impossible to fully overcome the fact of loss or prepare for it.

I was incited to learn more about staff and residents' perspectives on death after the passing of a white woman resident named Bea in 2015. Bea had stunning blue eyes and was in her 90s. She lived in the Alzheimer's wing and was almost totally silent. I took to feeding her breakfast and lunch almost daily over the course of three months. She ate little. Our choreographed feeding relied on an unsettled yet mutual dance of eye-to-eye and peripheral vision and my gentle commands to open and close her mouth after delivery of spoonful of food. It was sometimes messy and incoherent and sometimes satisfying and smooth. After a two-week getaway from field work, I returned to Withuis and found that she had died. A grey-colored tingling fell upon me when Ronette, a nursing aide, told me this. Bea had died in her sleep. Her body was still warm when Ronette found her during early morning check-ups.

A black woman caregiver named Mbali told me in 2015 about the more immediate experience of witnessing the moment of death while on duty: "The person will gasp. Do you know what that is? They gasp, and they ask for their daughter or someone else. When they ask for that person, we know they are getting ready to die. Then you find that when that one gets here, the person will just die." Have you seen them at the moment they die? I asked. "I've seen many people at the moment they die," she replied, "and it's mostly the same. Sometimes they want us to hold their hand." In another conversation on this topic, the white head nurse Noreen told me: "You know someone is dying. You can tell by the eyes, the skin, the breathing, and their mouth. The eyes begin to cover like a dead goldfish at the store; there is a film. Sometimes you can tell they will die, but sometimes you cannot."

In both Mbali and Noreen's accounts, visibly discernible physical attributes were evidence of dying and death. These were also the operable grounds for staff interventions, as in the case of Babsie's shallow breathing. Nursing staff had formal biomedical training and certifications that qualified them to work in this setting and treat or triage residents. Procedurally, the nursing staff on duty convened to call the family first and then the resident's listed doctor or a consulting doctor from a local public hospital. They also called the on-call nursing staff for reporting purposes. The resident's preferred morgue was contacted last. Touchingly, the staff tried to position bodies in a lying state, shut the eyes, dress them in their clothes, and ceremoniously cover them with a flower and sheets. Ronette, who told me about this small ritual, qualified the sheet as "white," a point I took to be more symbolic than literal since the linen supplies mostly consisted of faded pastels and prints.

Mbali's account also shows the social dimensions of biosocial dying. At the brink of physical cessation, the dying person sought a final tie, a touch or presence of another. This phenomenological encounter is ethnographically significant (Chatterji 2015). Kin of the dying were preferred in these final moments, but staff could otherwise stand in as "fleshy, imperfect specters" of real family members (Buch 2013, 643). The day I returned after my getaway, I looked at the visitors' log. Five days before Bea's death, two individuals named Brenda and Barbara Louise were listed as visiting her. Brenda came again four



days before the passing, leaving the comment “please phone.” On the day before Bea’s death, someone else wrote “please phone if anything changes.”

In their training, staff also learned to forge relationships of simultaneous closeness and detachment with the residents with the stipulation of not getting too close to them. Detachment, it was reasoned, was necessary for staff’s psychological and emotional well-being given the frequency of death. Staff told me they sometimes felt overwrought by residents’ deaths and buffered the experience by resorting to the home’s procedures and their own nursing training. However, they counteracted detachment by framing their work as more kin-like and unlike care received at public hospitals. Noreen said:

No. No. I am not used to [death]; you don’t get used to it; there are ways you can handle it, but it is never something that you get used to; There is a bond we have with the people who come here; this place is not like a hospital, where you go to see the person and they are asleep because they’ve taken their medicine, and then you come back later and they are still sleeping and recovering; we see them all the time and this place is their lives; we are their friends, family, everything when they come in here; so when they die that is then over.

Ayanda, a black woman caregiver, said:

They tell us in our training not to get too attached to the patients; this place is not like a hospital where people come and go; they stay here and we see them all the time when they are healthy and well; I don’t get too attached but it is hard sometimes.

Residents, however, perhaps because of their embodied proximity to death in their advanced age, seemed to accommodate it. Ambrose, a white man resident with epilepsy, who smoked and aided staff on shopping trips, told me in 2015, “I am used to death here; it doesn’t get to me, but I help others here because they can’t deal with it.” Ambrose’s own life partner, Pik died less than a year after they came to the home together in 2014: “I’ve seen it here and in my own life; I’m used to it now. When you’re in a place like this you get used to it.”

Residents’ and staffs’ moral and emotional experiences of others’ dying suggests that the home as a space of dying was not institutionally cold to them. It was humanely social: “we are their friends, family,” said Noreen, “everything when they come in here; so, when they die that is then over.” Residents sometimes had close relationships with each other based on rooming situations and daily interactions, but in the context of dementia-near-death these relations were also ambiguous. A week after a resident named Tish was taken to a hospital for falling into a coma, I asked her roommates Myra and Suzane if they had heard how she was doing. Suzane first said she did not know who Tish was. Myra recalled that Tish was their roommate but told us that she had died. “No man, that was Bea. She had beautiful eyes.” Suzane then remembered Tish was her roommate in contrast to Bea but knew not of Tish’s whereabouts.

This uncertainty of absence and presence also colored peoples’ ideas about the afterlife. Metaphysically, for staff and residents, a human person possessed an embodied phenomenon known as a soul or spirit that somehow continued beyond the moment of death. That a person goes “home” or to “heaven” were the most frequent answers to my question, “what happens when we die?” The egress and locale of these places, however, were often undefined.

Questions about post-mortem phenomena drew many references to popular Christian religious knowledge and what was learned from pastoral authorities. Sitting on lunch break with Ayanda and a black man caregiver Mbongi in March 2015, Ayanda said, “well, I don’t know what happens to the spirit, I should Google that. In our church we say that we die, and we are waiting for the second coming of Jesus Christ; It is not that the dead will rise again; it will be a spiritual resurrection, but I don’t know what happens to the spirit.” She did not mention hell.

I then asked Mbongi what happens after death, who suggested that all spirits go to heaven when they die. Ayanda quickly said that he was incorrect, arguing that some people clearly cannot go to heaven but not elaborating on why that would be. Her curt cut-off of Mbongi made me uncomfortable, and I spat out my own suggestion that we simply lose consciousness and life is extinguished like candle flame. To that, they both looked at me incredulously.

The next month, to the same question, Mbali told me, “hey, that thing, I don’t know.” Telling her about the information Ayanda learned from her church, Mbali went on, “Well, sometimes people go to heaven, they say, sometimes the spirit just goes around some place; like it doesn’t go anywhere; it is hanging around but the person is finished.” “Do they *lahlabantu*,” I asked, naming a regionally common Nguni rite of sweeping the site of a person’s death with a blessed tree branch. “Yes, that thing,” she said. “I grew up learning that some people go to heaven and others go to hell. I’ll probably go to hell,” I said laughingly. “That’s probably right,” Mbali said in a way I felt was void of irony. Precious, another caregiver joined us. “I don’t know,” she laughingly replied to the same question, “they say you go to heaven or hell. But if you die and it is not your time according to God, your spirit might just go around this place.” “You see what we think in our [black, Swazi, African] culture,” Mbali said, “but we don’t know.”

Finally, another month later, Precious and I urged one of the black residents, LaMatsebula, into giving her own explanation after her breakfast. LaMatsebula was a blind woman from Eswatini, who constantly talked in the mornings and evenings. She stayed and ate with the residents of the Alzheimer’s wing. “God chooses everyone,” she said, “but a soul becomes a spook that moves around here and there. They can be in the woods or the mountains. The body is in the ground and there are ancestors there. The spooks are everywhere, those that have no place. Sobhuza (a former King of Swaziland, ruling 1921-1982) and other amakosi are all around.” Amakosi, is a siSwati plural for chiefs, kings, spirits, and in its singular form, God, and spook or ispoki is a creolized Afrikaans-siSwati cognate for the English word ghost.

To recall the regional colonial history of land dispossession and migrancy, many black South Africans’ contemporary religious experiences are characterized by mobilities, displacement, and the uncertainty of bodily belonging to a place. According to White (2010), some Zulu-speaking peoples’ ancestors call upon them in dreams to create permanent dwelling space for them to reside in and construct small houses in a customary style, as they have otherwise been wandering lost in the afterlife. This cultural articulation converges with contemporary Pentecostal Christian religious rhetoric in the region, which cites that bodily materiality of the dead is inferior to the needs of a religiously cultivated soul or spirit (Golomski 2015). In the many worship services and bible study sessions I attended, pastors and speakers noted that preoccupations with problems of aching or dying bodies and their burial locale were misplaced, because in the greater metaphysical scheme of things, what really mattered was a spirit’s continuity through God’s immanent power in the present world.

## **Today is a present**

Lettie, a white former farmer, had since moved to a new room when I revisited Withuis one morning in May 2017. She was sitting at the edge of her bed and folding facial tissues in her hands. We greeted each other, and I asked her whether she had dreamt about anything that night. Sweetly, she told me: "We are already in heaven. When I dream, I dream of beautiful things like the sky and stars and moon." I replied that the dream sounded serene and asked what it meant that we were "already in heaven" while still here in this small town in South Africa. She explained, "In life we must do what God wishes. God has a plan. Those dreams show me that God is there."

The final line of the poem inspiring this article is "today is a gift, that is why it is called the present." It embodies the temporal orientation and meaning that residents and staff attributed to the end of life. With respect to imminent death, Babsie's story of her near-death experience was like several others I heard, that narrated a dynamic of being kept alive or moved from this present life according to God's preordination. Subjective volition in wanting to die made practical but not theological sense to many at Withuis, who claimed that death was not ultimately in their hands. Divinity suffused staff and residents' lives because its power was immanent. The borders between heaven and this world seemed to evaporate for some individuals like Lettie, reflecting a particular spatio-temporality in the home, one kind of "present" reality shaped by God's "plan."

Withuis and its parent organization were officially non-denominational, but, again, the home was strongly Christian. Several residents had framed inspiring religious quotes, Bibles, crucifixes, and rosaries in their rooms, and these objects were also found in most of the common areas. Every week they hosted a bible study run by a volunteer from the nearby town and a worship service run by a pastor of a Protestant church. Both were well-attended as being the only major events occurring on their respective days. Every morning around six o'clock, staff gathered at the nursing station to pass from the overnight to morning shifts. This meeting involved updating each other on residents' conditions, saying a prayer, and singing a few lines of a hymn. These rituals and the adornment of work-living spaces re-inspired people to go about their daily lives, movement which could be practically and personally difficult.

Maureen, another white, head nurse, often gave tours of the home to prospective residents' family members. One afternoon, she returned to the nurses' station after such a tour with a white woman, whose cascading auburn curls partially covered the remnants of tears on her face. "Ack shame we are full now," said Maureen, referring to Withuis being at maximum occupancy that month. "There is a long waiting list. But our in-take depends on God's plan. We will see who goes where. You see some may go from the independent living wing to the Alzheimer's wing. God is great." "God is good," the woman replied. Maureen concluded, "God's plan is what I see here every day." Later that month, God's plan for bed-space took shape when the adult children of a white resident named John removed him from the home after living there for half a year. The staff were relieved in John's move, as several qualified his unwillingness to eat and general disposition as "naughty."

Beyond workplace routines, God was also immanent in staff members' own daily existential concerns. Gladness was a 40-year old caregiver and grandmother who glared a shorn front tooth in her constant laughter. One day I found her in the Alzheimer's wing where she was animatedly telling the other black caregivers about her healthy CD4 count; her "soldiers" (emasotja) were strong these days, and others should go get theirs inspected too.<sup>7</sup> "Health is good," she explained, and doctors could easily do such a count at most clinics. To drive her point home, she then cited a sermon she heard in church about a man who lived and faced many challenges but persevered though the Holy Spirit to overcome them. The caregivers listened encouragingly. Going back on her rounds, she took with her a brochure for a local funeral parlor that the other caregivers were reading. Mbali, who was also HIV positive and often sent

me biblical quotes via text message, told me that she knew she would die sometime in the future and that is why she herself took out a policy with the parlor the year before.

Staff members desired to engender good “quality of life” for residents while they were still alive but took a practical day-to-day approach to residents’ treatment that also reflected their own awareness of material limitations. Preserving quality of life sometimes took form in keeping residents out of hospitals amid ongoing illness or injuries and instead treating them in the home. I learned this in Noreen’s description of Tish:

I don’t think she will last longer . . . changing her [diaper] we found a growth in her abdomen. The doctor suggested we take her for a CT scan. But we made a collective decision. We said, ‘what is the point? Why must we put her through the pain of driving in the car, being uncomfortable, and lying in a bed in [the nearby public hospital] and then if they find something, then what? What can we do?’

Discerning that Tish would likely neither survive an operation or the aftercare at the hospital, the staff colluded to palliate her at Withuis. A week prior, Maureen showed me a large brown file thick with Tish’s hospital records which Marina said they “borrowed” indefinitely because they perceived it would inevitably be lost or unavailable if they took her back to the hospital. Their previous experiences steered them to wait things out for a while in the home instead.

This decision offers a contrast to more resourced frail care settings. Staff in Danish nursing homes, for people with dementia, explicitly call their charges “citizens.” This evinced socio-cultural and political ideas about residents’ progress and futurity, in that under their care, they would “never be too frail for self-realization” as citizens of the welfare state (Svensen et al. 2018, 29). Danish staff members’ position hinged on a cultural move of “substituting” aspects of residents’ personhood with respect to time. For these older human beings with diminished capacities, staff re-imagined alternative temporal horizons for them—one of daily “fulfillment” rather than prolongation in successive treatments—as residents would otherwise not strongly articulate this process for themselves.<sup>8</sup>

In Withuis, for staff at least, contemporary (versus past) state health and social welfare institutions in the form of public hospitals are not typically salvific resources. A retreat to a “home” is a more compelling option. Also, staff and residents shared cultural scripts about temporality as God’s gift of the present in which they were both variably imbricated, which contrasted with the more unidirectional substitutions based on time in the Danish case. Despite illustrating a similar orientation of care in Denmark, these South African residents and staff’s shared political history, relative poverty, and religiosity shaped and located their sense of the present in the home as a portal to the next life.

## Conclusion

The sociopolitical and racial landscape of post-apartheid South Africa is in a perpetual state of suspension. Radical change was supposed to happen after the 1990s political transition. The old was supposed to converge with the new, seamlessly and colorlessly, according to the much-touted post-racial, multiculturalist Rainbow Nation ideology. The symbolic freight of this promise, however, is continually laid bare in the present. Did we witness these changes in this lifetime? If not, where do we instead see ourselves now?

Narratively re-articulating lived experiences of the past in the present is theorized to be a source of interpersonal or social transformation (Mattingly 2018; Krog, Mpolweni and Ratele 2009). Still,

narrative is challenging, especially when we situate practices of storytelling in cultural context and a particular life course phase. The ethnographic specificity of this home and proscriptions for both sociality and research therein perhaps reveal the limits of narrative as a medium of evidence to support theories about immanence as a moral and ethical concept.

The enduring structural violence of the (post)colonial political economy is immanent in everyday life in South Africa and, for many, already embodied (Fassin 2013). Racism is pervasive and systemic in the present as the policy-based foundation of apartheid and prior colonial orders. At the level of narrative articulation among interracial and unequal relationships of caregiving and receiving, it can burst in at any moment. It is both immanent and imminent, but it is held in abeyance in the face of frailty and mortality. History as embodied in an older adult and their life stories dissipates in their potential death. For staff, beholding dementia (-near-death or otherwise) also shores up the fact that pasts can be forgotten on one's own terms or due to senescence. These contradictions, I argue, were reconciled temporally with reference to another pervasive force in the lives and times of staff and residents: God.

For people at Withuis, both younger caregiving staff members and those who lived through apartheid, foregrounding God's presence was a way to re-qualify difficult life conditions and transitions they faced as pre-ordained or perhaps something good. This was despite and because of life's imminent complications related to HIV, poverty, and even death in this care-fully guarded home. Mortality as a universally recurring yet shiftily defined event was configured by God. It occurred on His time, and He was its silver lining. He, and death were here all along. This religious orientation turns out to be a temporal one as well, as the present is divined to be a gift from God Himself. It reflects aspects of what scholars of aging call gero-transcendence, where older adults may become more self-reflective or meditative and reorient toward cosmic dimensions of existence and an acceptance of death (Bohman, van Wyk, and Ekman 2010) and here, conditioned by local Protestant eschatologies (Bafford 2019).

In sharing their understandings of dying under God's watch, residents and staff did not deny that their lives were physically or emotionally painful. This hurt was indeed immediate. Yet, the space within which it was felt was culturally and religiously shaped insofar to engender meaningful, indeed, livable experiences of time itself in the midst of dying. In tracing peoples' experiences of working through waiting with-in God's mysteries of death, we see that the sacred is perhaps as immanent in the aftermath of violence as it is usually seen in situations of healing. To wit, an ethnography of aging and dying in a site like this allows for a graying of postcolonial histories and temporal linearities often construed in more "black" and "white" terms.

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## **Notes**

1. Withuis is a pseudonym, like all individuals' names mentioned in the text. I retain the local vernacular of frail care home (versus nursing) to reiterate the cultural framing or scripts in play about what it means

to age and what to do about it in South Africa, there as it signals accommodating bodily debility (“frail care”) rather than biomedical treatment (“nursing”).

2. Social personhood, for example, may be diminished in “dementia-near-death,” where an individual’s ability to move (their own) social life forward in communicative interaction is curtailed despite the continuation of other biological functions (Kaufman 2005).

3. Lambek’s definition is but one in a robust subfield focused ethics and morality, the breadth of which cannot be covered here. Lambek’s approach is widely cited and also critiqued on both methodological and theoretical points (Lempert 2015; Zigon 2018).

4. For Mattingly (2018, 48), “narrative is needed to consider the temporality of the self,” and following the philosopher Ricoeur, “lived experience is already narratively prefigured.”

5. A caveat regarding the expressive abilities and ideations of death of residents with dementia as arguably (in)comparable with ideations of staff and residents not living with dementia: anthropologically, we know claims about incommensurability inhere a kind of knowledge production that operates on essentializing difference. Handler (2009, 627) notes when one claims things are incomparable, it is as if “two phenomena cannot be compared when they mean to rank one decisively above the other,” i.e. that staff’s coherent ideations are somehow more logical or legitimate than ideations of a resident who lives with dementia. This is a cognitivist bias that I try to avoid by taking a culturally relativist mode in acknowledging both groups’ perspectives as biosocially distinct and historically coeval.

6. Frail care homes in South Africa are not hospice homes. Staff members were not aiding the dying process, although they could contract with a local branch of a national hospice network should the client or her or his family desired this option.

7. Influenced by decades of public health communication and education for people living with HIV/AIDS, the surface proteins of T-cell lymphocyte white blood cells are called “soldiers” in Southern Nguni vernacular languages.

8. To make this argument, the authors interestingly compare cases of people living with dementia-near-death to neonates and research-lab piglets to investigate the ways temporality is substituted for or applied to forms of life more broadly.

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